EXECUTIVE SUMMARY

INTRODUCTION

This Executive Summary provides an overview of the concerns and recommendations presented in the Initial Report of the Medical Board of California (MBC) Enforcement Program Monitor (Monitor).

As a result of the Legislature's 2001–02 sunset review of MBC, Senate Bill 1950 (Figueroa) added section 2220.1 to the Business and Professions Code,[1] which provided for the appointment of an independent enforcement monitor and charged the monitor with evaluating "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." The statute tasks the Monitor with several specific analyses, including a required evaluation of the Board's diversion program for substance-abusing physicians.

The MBC Enforcement Monitor project began in late October 2003, and will continue through November 1, 2005. The Monitor and her colleagues — with the full cooperation of the management and staff of both the Medical Board and the Health Quality Enforcement Section of the Attorney General's Office — have studied the legislative history of six major legislative enactments that have shaped the structure and purpose of MBC's enforcement program; surveyed previous studies and reports on MBC's enforcement and diversion programs; reviewed MBC-generated documents and procedure manuals relevant to its enforcement and diversion programs; interviewed 92 experts and witnesses; gathered and analyzed statistical data; and conducted extensive research into initial issues and concerns relating to the Board's enforcement and diversion programs.

During 2005, the Monitor will present the findings and recommendations in this Initial Report to the Joint Committee on Boards, Commissions and Consumer Protection at the Board's sunset review proceeding, draft and advocate 2005 legislation to implement Monitor

[1] Unless otherwise noted, all further statutory references in this Executive Summary are to the Business and Professions Code.

recommendations that require legislative approval, and study several components of the Board's enforcement program that we were not able to cover in depth this year.

In this report, the Monitor makes findings and recommendations which may be addressed on a number of levels — internal administrative or procedural change, regulatory amendment, legislative change, budget and staffing enhancements, and/or structural change. Some of these recommendations are concrete and ready for consideration by the Board. Others are less fully developed concepts whose merits and precise implementation will be the subject of discussion between the Monitor and all of the stakeholders during 2005. Finally, others urge the Medical Board to engage in a constructive public dialogue on certain issues, having been fully informed by the discussion contained and data revealed in this report.

This Executive Summary presents the major findings and recommendations of the Initial Report using the following organizational scheme:

- Introduction
- Overview of MBC and its Enforcement Program
- The Evolution of MBC's Enforcement Program
- MBC's Enforcement Program: General Description and Threshold Concerns
- Complaint Receipt and Screening: Central Complaint Unit
- Field Investigations: District Offices
- Expert Reviewer Program
- Prosecutions: Health Quality Enforcement Section
- Hearings: Medical Quality Hearing Panel
- Decisions: Division of Medical Quality
- Judicial Review of DMQ Decisions
- Public Disclosure
- Public Education and Outreach
- MBC's Diversion Program
- Issues for Final Report
- Conclusion

OVERVIEW OF MBC AND ITS ENFORCEMENT PROGRAM

Created in the Medical Practice Act, the Medical Board of California (MBC) is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members: twelve California-licensed physicians and nine non-physician "public members," all serving four-year terms. Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). DOL, which

consists of four physicians and three public members, focuses on the licensure of physicians and the regulation of several non-physician health care professions. DMQ, which consists of fourteen members (eight physicians and six public members), is the Board's enforcement arm. DMQ is responsible for reviewing the quality of medical practice carried out by its physician licensees, conducting disciplinary proceedings in cases of unprofessional conduct, and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable professional standards. The Legislature has declared that, in exercising its disciplinary authority, "[p]rotection of the public shall be the highest priority for the Division of Medical Quality . . . . Where [physician] rehabilitation and protection are inconsistent, protection shall be paramount."

The Business and Professions Code sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by "clear and convincing evidence to a reasonable certainty." The Code also sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, the issuance of a public reprimand, citations, fines, and civil penalties.

In 2003–04, MBC regulated over 117,000 physicians, of which 91,000 reside and practice medicine in California. The Medical Board receives no funding or support from the state's general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a "special-fund agency." In 2003–04, MBC's annual budget was $38.5 million, of which $28.2 million — or 73% — was spent on enforcement.

THE EVOLUTION OF MBC'S ENFORCEMENT PROGRAM

Chapter IV of this Initial Report describes the evolution of the Board's enforcement program through the enactment of six pieces of landmark legislation over the past 30 years. These bills — AB 1 (Keene) in 1975, SB 2375 (Presley) in 1990, SB 916 (Presley) in 1993, SB 609 (Rosenthal) in 1995, AB 103 (Figueroa) in 1997, and SB 1950 (Figueroa) in 2002 — have largely shaped the purpose, structure, authority, and resources of the Medical Board's enforcement program.

MICRA and the promise of balanced reform. Prior to 1975, the former "Board of Medical Examiners" — a physician-dominated board which exercised its disciplinary authority through regional "medical quality review committees" also controlled by physicians — was largely ineffective in disciplining physicians for negligence or incompetence. Instead, patient injury caused

by physician negligence or incompetence was handled through the civil tort system. In 1975, medical malpractice insurers announced massive premium increases, allegedly needed to pay jury verdicts and remain profitable. Outraged physicians turned to the Legislature for a solution. The result was AB 1 (Keene), the Medical Injury Compensation Reform Act of 1975 (MICRA), a measure carefully designed to comprehensively address three issues — tort reform, medical quality control, and insurance regulation — that were of interest to the four sets of stakeholders "at the table" (physicians, lawyers, insurance companies, and patients). According to Assemblymember Keene, "[a] general policy . . . decision was made that all interested parties must sacrifice in order to reach a fair and rational solution to the insurance crisis. AB 1 was drafted to include all reforms in order to prevent any one interest group from sabotaging any single-objective bill."

In its tort reform provisions, AB 1 capped non-economic damages (such as pain and suffering) in medical malpractice actions at $250,000; limited the contingency fee that plaintiff's counsel may charge in medical malpractice actions, provided (under the so-called "collateral source rule") that the jury in a medical malpractice action may be told of certain benefits payable to plaintiff (such as social security payments and benefits received under group health plans); and imposed a number of other disincentives to the filing of medical malpractice actions.

In exchange for these unprecedented concessions, the medical profession agreed to accept and support enhanced regulation of its ranks — with an emphasis on policing the quality of medical care provided and the removal of incompetent and negligent physicians from the marketplace. According to Assemblymember Keene, "[h]ealth quality control provisions were essential to regain public confidence in the health care delivery system, and to assure that incompetent doctors are not allowed to practice and generate lawsuits."

To implement health quality control, AB 1 abolished the Board of Medical Examiners and created a new "Board of Medical Quality Assurance" (BMQA) consisting of 19 members — twelve physicians and seven public members. For the first time, a dedicated enforcement arm — the Division of Medical Quality — was created and charged with overseeing the Board's enforcement staff, reviewing the quality of practice carried out by physicians, and making decisions in disciplinary matters. AB 1 also established a "central file" mechanism to capture information on complaints and reports of misconduct against physicians; set the stage for the transfer of investigative authority and the investigative function (in the person of professional investigators who would specialize in physician discipline matters) from DCA to BMQA; and established a number of "mandatory reporting requirements" to assure that actions taken by other entities against potentially dangerous doctors are reported to the Board so that they might be investigated and appropriately disciplined. AB 1 thus formed the promise of balanced medical regulatory reform for California.

SB 2375 (Presley). Despite AB 1's influx of authority, information, and resources to BMQA, a series of reports during the 1980s indicated that BMQA's effectiveness in policing the

medical profession was doubtful. The Auditor General, Assembly Office of Research, Little Hoover Commission, and Legislative Analyst all found fault with the Board's public outreach, mounting case backlogs, and overall enforcement performance. In April 1989, the Center for Public Interest Law released a report entitled *Physician Discipline in California: A Code Blue Emergency*, which further documented the minimal output, fragmented structure, and questionable priorities of BMQA's enforcement program. *Code Blue* called for increased resources and structural reorganization of BMQA, the Attorney General's Office which prosecutes MBC enforcement cases, the Office of Administrative Hearings whose administrative law judges (ALJs) preside over MBC disciplinary hearings, and the courts' review of MBC disciplinary decisions. BMQA rejected *Code Blue*'s allegations, contending that any flaws in its enforcement performance were due to the state's failure to approve additional enforcement program staffing and to factors beyond its control; it opposed any structural reform and decided only to change its name to "Medical Board of California" (MBC).

However, the impact of *Code Blue* and a series of events during 1990 — including a judge's public castigation of MBC for its failure to discipline Dr. Milos Klvana, a physician whose negligence had resulted in the deaths of nine infants; the Legislature's decision to withhold one-half of MBC's budget until it addressed a backlog of almost 900 uninvestigated cases; and a national report ranking MBC 42nd among the states in the number of serious disciplinary actions taken against physicians — combined to bring about the 1990 passage of SB 2375 (Presley), the first major MBC structural reform bill since AB 1 in 1975.

SB 2375 created a new Health Quality Enforcement (HQE) Section in the Attorney General's Office whose prosecutors were directed to specialize in medical disciplinary matters and to "work closely with each major intake and investigatory unit . . . [of MBC] to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations." Similarly, SB 2375 created the Medical Quality Hearing Panel, a specialized panel of ALJs within the Office of Administrative Hearings to hear medical discipline cases, and authorized those ALJs to issue "interim suspension orders" to immediately halt the practice of very dangerous physicians in egregious cases. The bill also enhanced required reporting to the Board on physician negligence and misconduct; increased the maximum penalty against hospitals and HMOs that fail to report adverse peer review action to MBC; required MBC to compile and report certain disciplinary information to the Legislature and the public in its annual report every year; required DMQ to establish a goal of allowing no more than six months to elapse from receipt of a complaint to completion of the investigation; and — perhaps most important — clarified that protection of the public is DMQ's "paramount" priority in exercising its disciplinary authority.

MBC and HQE began to implement SB 2375 in 1991, but both were understaffed and unable to fully comply with the law's requirements of HQE presence at MBC's complaint intake and

investigative offices. In 1991, the Auditor General found that MBC was unable to meet the bill's six-month investigation goal — in fact, the average MBC investigation took 14 months to complete. Exacerbating the investigative delay, HQE took over 200 days to file an accusation in a fully investigated case, and another 264 days elapsed from the filing of the accusation to the completion of the hearing by OAH. In sum, DMQ, HQE, and OAH took an average of 2.8 years to process a serious discipline case from receipt of the complaint to a disciplinary decision (which is then subject to judicial review). The Auditor General also questioned the Board's 1990 closure of a number of cases that had been referred for investigation. In 1992, allegations by MBC's investigators about the closure of those complaints resulted in a formal audit of MBC's enforcement program by the Bureau of Internal Affairs of the California Highway Patrol (CHP).

The CHP Report and SB 916 (Presley). The findings in CHP's January 1993 report — which were widely reported in newspapers across the state — rocked the Board. CHP found that, in 1990, MBC had dispatched a "three-member management team" to the Board's investigative offices which ordered the closure of 200–300 cases. In addition to the improper closure of those cases, CHP found that other cases had been "poorly investigated" and inappropriately closed. CHP's report prompted calls for the repeal of MICRA in many quarters, based on the conclusion that the promised balance of medical regulatory reforms had not materialized. In particular, critics argued that if the "enhanced" MBC regulatory system was not working for consumers, then MICRA's benefits to the medical profession and insurance industry should be repealed. In March 1993, MBC responded to the CHP report by convening a two-day "Medical Summit" of community, consumer, and medical profession leaders to discuss these problems and identify solutions. Several proposals raised at the Summit were amended into SB 916 (Presley), Senator Presley's follow-up legislation to 1990's SB 2375.

Enacted in 1993, SB 916 (Presley) contained a number of reforms responsive to the CHP report and raised at the Medical Summit, and other proposals that had introduced in but amended out of SB 2375 in 1990. SB 916 enhanced MBC's detection of problem physicians by requiring hospitals and health care facilities to expedite the filing of reports on adverse peer review actions; requiring plaintiffs to notify MBC of their intent to sue a physician for medical malpractice; and requiring medical societies, health facilities, government agencies, and others who receive complaints about physicians to inform the complainant that only MBC is authorized to take disciplinary action against physicians. SB 916 improved the authority of MBC investigators to request and receive medical records from physicians under investigation, and authorized the imposition of a $1,000-per-day fine on physicians who refuse to comply with a lawful MBC request for medical records. The bill also established intermediate sanctions for offenses that do not merit revocation; abolished the Board's MQRCs; authorized DMQ to establish panels or lists of experts to assist it in administering its enforcement program; streamlined judicial review of MBC disciplinary decisions; expanded the Board's public disclosure policy; and authorized MBC to increase its biennial renewal fees from $500 to $600.

SB 609 (Rosenthal) and AB 103 (Figueroa). The goals of SB 916 were furthered by the passage of two subsequent bills. SB 609 (Rosenthal) in 1995 revised DMQ's disciplinary decisionmaking process and the procedure for judicial review of DMQ decisions. AB 103 (Figueroa), enacted in 1997, expanded MBC's public disclosure policy, requiring MBC to post on the Internet information about its licensees' current standing, prior disciplinary action, felony convictions reported to MBC after 1991, current accusations filed by the Attorney General, all malpractice judgments and arbitration awards reported to the Board after 1993, and all hospital disciplinary actions resulting in the termination or revocation of a physician's staff privileges for medical disciplinary cause or reason.

In January of 1997, HQE and MBC — dissatisfied with the length of time that fully investigated cases sat at HQE before accusations were filed — formally implemented SB 2375's requirement of HQE assistance for MBC investigators by launching the "Deputy in District Office" (DIDO) program, whereby an HQE DAG physically works in MBC district offices one or two days per week to permit onsite prosecutor guidance of investigations. By July of 1998, after phasing in the DIDO program and other changes, HQE had dramatically reduced average time for filing pleadings, down from 134 days to 28 days from case transmittal.

MBC's 1997–98 sunset review. The DIDO program and other factors accumulated to stretch MBC's enforcement budget to its breaking point. During the late 1990s, MBC experienced a 23% increase in complaint volume with no corresponding increase in investigative staff, excessive caseloads for MBC investigators, and a 10% vacancy rate in investigator positions because trained MBC investigators were leaving the Board for other agencies with higher pay and lower caseloads of lesser complexity. Faced with California Medical Association (CMA) opposition to a license fee increase, MBC implemented its "cost recovery" authority (under which it may be reimbursed for some of its investigative and enforcement costs by disciplined physicians) and scoured its budget for other revenues that could be redirected to enforcement. These tactics forestalled a fee increase request until 1998, when MBC underwent its first "sunset review" by the Joint Legislative Sunset Review Committee (JLSRC). Although the JLSRC recognized "a significant increase in the number of complaints filed" with MBC between 1992–93 and 1996–97, it also found that MBC had (since 1994–95) slashed its overall case processing time in most areas and increased its disciplinary output — largely due to the centralization of the complaint intake process and the recent success of the DIDO program in reducing accusation filing time. Although JLSRC staff stressed that MBC's average investigative processing time was 13 months (as opposed to the six-month goal established in SB 2375) and recommended that a fee increase be considered, the Joint Committee declined to approve a fee increase to support additional investigators.

When it became clear that sunset review would not yield the increase it had delayed since 1995, MBC sought the increase through the Department of Consumer Affairs' 1998 omnibus fee bill.

The Board sought a $90 biennial increase to finance ten new investigator positions and cut the 13-month average investigative lag time; it also needed additional revenue because employee salaries had been raised after a four-year cap, and a new Department-wide computer system requiring MBC contribution was on the horizon. CMA announced it would consider an increase only if the Board agreed to a full review of the performance of and costs charged by HQE, the elimination of cost recovery, a redefinition of the "repeated negligent acts" basis for discipline, and an alternative to section 805 reporting for physicians who "voluntarily" take a leave of absence from their hospital privileges to check into drug/alcohol treatment programs. The Board refused to agree to these terms, and CMA's opposition resulted in the deletion of MBC's fee increase from the omnibus bill. Upset with CMA for its refusal to support the Board's enforcement program, several Board members called for repeal of MICRA's cap on noneconomic damages in medical malpractice actions. According to one Board member, MBC must "support upward modification of the MICRA cap so that California's citizens would, lacking administrative redress, have greater access to civil redress."

MBC reintroduced its fee increase legislation in 1999, arguing that its fees had not been adjusted since 1994, and its investigative staff had not been increased since 1992. Since that time, the Board had experienced a 60% increase in the number of complaints received. In addition, MBC contended that its investigators carried higher caseloads than investigators at other state agencies. In response, CMA introduced competing legislation that would afford the Board a fee increase in exchange for 14 substantive changes in MBC's procedures and disciplinary authority. After negotiations throughout 1999, CMA reduced its 14 demands to five by January 2000: (1) redefinition of "repeated negligent acts" to preclude discipline for actions "during a single course of treatment" unless the physician's actions constitute "a pattern of conduct likely to jeopardize patient care"; (2) an amendment to section 805 prohibiting hospitals from notifying MBC's enforcement program when a physician takes a leave of absence in order to enter substance abuse treatment; (3) imposition of a mandatory $6,000 cap on cost recovery for physicians; (4) a requirement that MBC adopt regulations codifying enforcement program priorities that mandate "the prioritization of cases involving a serious risk to patient safety for investigation and prosecution"; and (5) a 50% reduction in initial license fees for physicians who are in residency programs. In exchange, CMA offered a $90 biennial fee increase. At its July 2000 meeting, the Board rejected CMA's offer, deciding that the bill's concessions in terms of consumer protection were not worth the resources offered by the bill. In fact, MBC determined that the bill would not increase resources for the Board's enforcement program and that the cap on cost recovery might backfire and actually decrease enforcement program resources. Both bills died in 2000.

As of October 2001, the state-imposed hiring freeze temporarily mooted the fee increase issue as state agencies, including special-funded agencies such as MBC with no impact on the general fund, were prohibited from filling vacant employee positions. The impacts of the hiring freeze — which lasted until June 2004 — and subsequent legislative actions abolishing vacant

positions have had devastating impacts on the Board's enforcement program. Since 2001, MBC has lost a total of 44.8 staff positions — including 29 enforcement positions. MBC's field investigations staff was reduced from 90 in 2000–01 to 71 by June 30, 2004 — a 25% loss. Since the hiring freeze began in October 2001, HQE has lost a total of six prosecutor positions — all in its Los Angeles office; in addition, two Los Angeles HQE deputies are out on extended medical leaves.

2001–02 sunset review and SB 1950 (Figueroa). In the meantime, MBC began its second sunset review in December 2001 with enforcement output data that had declined since its first review. As the Board prepared for its final sunset hearing in the spring of 2002, a wave of media stories criticized its public disclosure policy and overall enforcement performance. In particular, the *Orange County Register*'s April 2002 "Doctors Without Discipline" series was disturbingly reminiscent of the *Los Angeles Times*' coverage of the Klvana case twelve years earlier, in that it focused primarily on MBC's handling of one obstetrician who had botched deliveries and injured or killed infants. The series illuminated a lengthy eight-year delay between the Board's 1993 receipt of a section 805 report on the physician and its 2001 filing of an accusation against the physician; MBC's failure to seek an interim suspension order against the physician until 2002, despite multiple complaints, investigations, lawsuits, section 805 reports, and patient deaths; its declining enforcement output; its failure to check court files for the filing and outcome of medical malpractice actions; its "mandatory" reporting statutes that were easily evaded by physicians (and their lawyers) who wished to avoid being reported to MBC; and its loopholed public disclosure policy.

The *Register* series prompted the Joint Legislative Sunset Review Committee to postpone MBC's sunset hearing while its staff conducted an investigation into the mechanics of the Board's enforcement program. Staff's background paper found that: (1) every category of Board enforcement activity had declined since its last sunset review, even as complaints from patients increased; (2) few complaints become the basis of a formal investigation, few investigations lead to an accusation, and few accusations result in administrative hearings; (3) internal Board practices require the routine closure of most quality of care patient complaints because they fail to satisfy the "gross negligence" basis for discipline — closures that occur without routine consultation with a specialist in the same field, without review by HQE, and without consideration whether they may constitute "repeated negligent acts" or "incompetence"; (4) the Board does not receive all the information to which it is legally entitled; (5) MBC's complaint and investigation priorities are questionable; and (6) the Board's public disclosure policy misleads the public by failing to disclose malpractice settlements and misdemeanor criminal convictions — information deemed essential to every other medical stakeholder's evaluation of whether to associate with a physician.

MBC's 2001–02 sunset review resulted in the passage of SB 1950 (Figueroa), which attempted to address the flaws in MBC's enforcement program illustrated in the media reports and its sunset review. SB 1950 created an independent "enforcement monitor" charged with reviewing

MBC's enforcement and diversion programs for a two-year period. The bill established a list of five types of "priority cases" whose processing, investigation, and prosecution should be expedited by MBC and HQE; set forth a new complaint processing procedure that requires quality of care complaints to be reviewed a specialist with the "pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint" before they may be referred for investigation; closed loopholes in the Board's mandatory reporting statutes; expanded MBC's public disclosure policy and authorized it to disclose information about some civil malpractice settlements; revised the definition of "repeated negligent acts"; and revised the Board's composition by adding two new public member positions.

This thirty-year evolution of MBC's enforcement program serves to remind policymakers and stakeholders that the fundamental premise underlying the program is the balance of regulatory reforms so carefully crafted in AB 1 (Keene) and its progeny. The MICRA bill offered and still offers the promise of improving the future of the regulation of medical practice in California for all parties. But the long series of critiques, studies, and attempted legislative solutions reviewed here indicates that the disciplinary effectiveness portion of the reform program has consistently lagged. Further work remains to be done to fulfill the 30-year promise of balanced reform.

MBC's ENFORCEMENT PROGRAM: GENERAL DESCRIPTION AND THRESHOLD CONCERNS

A. General Description of Functions

MBC's enforcement program is large, complex, fragmented, and expensive. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at twelve (12) district offices throughout California. Once DMQ's investigative staff (assisted by physician employees called "medical consultants" and often external expert physician reviewers) have determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement (HQE) Section of the Attorney General's Office; HQE has six offices throughout the state. A deputy attorney general (DAG) from HQE then files an "accusation," a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings, at which each side presents its case. After the case is "submitted," the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended discipline. That proposed decision is referred back to MBC's Division of Medical Quality, where it is reviewed by one of two "panels" of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ

panel makes MBC's final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to eight years, during which time most respondent physicians are free to continue practicing medicine.

B. Threshold Concerns about MBC's Enforcement Program

1. Overall, the enforcement process takes too long to protect the public. The average length of time for a serious complaint to reach its disciplinary conclusion during 2003–04 was 2.63 years. Many cases take much longer. The total average time from the filing of a serious complaint to a judicially-reviewed disciplinary decision is thus 1,369 days, or 3.75 years. MBC does not control all of this process, but MBC and HQE have direct control over the complaint processing, investigation, and prosecution activities of this process, and must target and attack these troubling delays.

2. MBC resources are inadequate. In recent years, the Medical Board has suffered a devastating combination of blows to its funding and staffing, including:

An outdated license fee structure in which its $600 biennial renewal fee was last adjusted in January 1994, despite a 27.9% increase in the California Consumer Price Index in that period. If $300 per year was an appropriate license renewal fee in 1994, it is 28% less appropriate today. In MICRA, the medical profession agreed to a balanced reform program in which it received an unprecedented cap on malpractice damages in exchange for strengthened Medical Board enforcement to address dangerous or incompetent physicians. MICRA's $250,000 malpractice cap has been frozen since 1975, providing much greater real dollar protection for physicians, but MBC's resources to protect the public have been effectively reduced by 28% since 1994.

The statewide hiring freeze of 2001–03, and resulting position losses, cost MBC a total of 44.8 staff positions, including 29 enforcement program positions. In 2004, MBC's enforcement program staff consists of 20 fewer positions than it had in 1991–92, when it received 22% fewer complaints and took 75% fewer disciplinary actions. HQE has lost six DAG positions — all in its Los Angeles office, and OAH lost two ALJ positions. The loss of its enforcement program positions required MBC to disband Operation Safe Medicine (its proactive program to target unlicensed "back-room clinics" in low-income areas), eliminate an Internet Crimes Unit targeting unlawful Internet drug sales, and ask its supervisorial investigators to take on partial caseloads.

Increased costs of doing business, such as salary adjustments and benefit premium increases, have continued notwithstanding the hiring and budget freezes.

MBC estimates that it will need a fee increase to $800 biennially to support a restoration of service levels comparable to 1994. The proposed fee level is comparable to the license fees charged

by other similar agencies, such as the Board of Podiatric Medicine's $900 biennial fee and the State Bar's $390 annual fee.

3. MBC and HQE's management structure and information systems need improvement. The Monitor has a number of concerns about various aspects of the management structure and management information systems of both MBC and HQE.

Medical Director position. MBC lost its Medical Director position during the hiring freeze and "sweep" of vacant positions. Reinstatement of this important post is a priority for MBC management, and the Monitor supports that effort.

Diversion Program management. For many years, the Medical Board has permitted the Diversion Program to effectively function in a vacuum, separate from overall MBC management, resulting in breakdowns in key Diversion functions that pose a risk not only to the public but also to the physicians participating in the Program. The administration of the Diversion Program must be more fully integrated into MBC management.

Relationship between MBC and HQE. The statutes creating and delegating responsibility to HQE require it to direct discipline-related MBC prosecutions and to assist DMQ in intake and investigations. The much delayed Deputy in District Office (DIDO) program has provided investigators with legal guidance, lowered accusation filing times, and is better than the prior "hand-off" structure, but it has proven unsatisfactory in many respects. The "vertical prosecution" model first suggested in 1990 would resolve these problems and should be revisited.

Enforcement policy/procedure manuals. MBC has a multitude of enforcement policy and procedural manuals, many of which are not regularly updated and most of which are inadequately reviewed by HQE. These update and review functions should be performed routinely and on a regular basis. HQE has no procedure manual at all.

Management information systems. MBC's management information system (the CAS system shared with other Department of Consumer Affairs agencies) suffers from numerous inadequacies and problems impeding MBC's licensing and enforcement programs, and undermining its public disclosure program. Similarly, the Attorney General's Office has long lacked an adequate management information system to capture accurate information on its processing and prosecution of disciplinary matters, and is only now implementing its improved ProLaw system.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #1: Lost enforcement positions should be reinstated. MBC should continue its efforts to reinstate the 29 abolished enforcement positions and four HQE attorney

positions, to enable the Board to rebuild its enforcement program, recreate Operation Safe Medicine and its Internet Crimes Unit, and expedite the processing of quality of care cases.

Recommendation #2: Renewal fees should be increased. The statutory ceiling on the Board's $600 biennial license renewal fee should be increased to $800 to cover inflation, restoration of lost enforcement positions, and increased costs of doing business.

Recommendation #3: DCA and MBC must upgrade their management information systems.

Recommendation #4: MBC should regularly update all enforcement manuals, and HQE should draft a policy and procedure manual.

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

A. General Description of Functions

The Medical Board's Central Complaint Unit (CCU) is responsible for receiving, acknowledging, screening, and processing all complaints and reports the Medical Board receives about the medical care provided by and conduct of California physicians. CCU is located in Sacramento, and is currently staffed by two managers, 15 analysts, 5 management services technicians, and a number of support staff, as well as a cadre of physician "medical consultants" under contract with the Unit who review complaints and medical records to assist in determining whether complaints should be referred for formal investigation. As of October 2003, an attorney from the Health Quality Enforcement Section and a MBC supervising investigator were assigned to CCU. In 2002, CCU was divided into Quality of Care (QC) and Physician Conduct (PC) sections. Staff of these sections review and analyze incoming complaints and reports; if necessary, secure medical records of the complainant and ensure their review by a medical consultant; and determine whether each should be closed or forwarded to one of MBC's twelve regional district offices for formal investigation.

Chapter VI provides a detailed description of CCU complaint initiation and processing (before and after significant 2002 changes); the division of the CCU into its two constituent sections and their functions; CCU case processing priorities after SB 1950; the "specialty reviewer" requirement for QC cases; the recent additions of an HQE attorney and an MBC investigator to assist CCU's operations; review of "simple departure" matters; sources of complaints and reports resulting in investigation and disciplinary action, including action in SB 1950 "priority cases"; and a note on the medical marijuana issue.

B. Initial Concerns of the MBC Enforcement Monitor

1. CCU's average complaint processing time is longer than historically reported. CCU has been counting as "complaints" several categories of information — including notices of intent to file lawsuits (NOIs), National Practitioner Data Bank (NPDB) reports, and "change of address citations" — that should not be counted as complaints. As a result, CCU's reported complaint total is artificially high and its reported average complaint processing time is artificially low. Factoring out these items yields a total of 8,240 complaints received in 2003–04 and a 79-day average CCU case processing time.

2. CCU complaint processing takes too long. Business and Professions Code section 2319(a) establishes a goal of six months' elapsed time for MBC to handle a complaint through the completion of the investigation (one year in complex matters). This timeframe includes CCU case processing time. CCU's 2003–04 average case processing time of 79 days (2.63 months) is 12 days longer than it took CCU to process complaints in 2002–03.

CCU's processing of quality of care cases — which requires the procurement of patient medical records and the review of those records by a "specialty reviewer" — took an average of 140 days in 2003–04. Approximately 10 of those days were consumed by complaint receipt and initiation; medical records procurement took 66 days; and medical consultant review took another 64 days. Thus, CCU's processing of QC complaints consumes 140 days of the 180-day goal in section 2319(a).

3. CCU's implementation of the specialty reviewer requirement for QC complaints has caused a number of problems. Effective January 1, 2003, SB 1950 (Figueroa) added section 2220.08, which requires CCU to ensure that QC matters are reviewed by a physician "with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." This "specialty reviewer" requirement has required CCU to recruit and train new medical consultants in a number of different specialties and subspecialties so that QC complaints can be reviewed by a physician with relevant expertise. The Monitor studied the time it took CCU to locate a reviewer and secure review of relevant medical records during calendar year 2003. In five "high-volume" specialties (those that are often the subject of complaints and in which CCU has a number of experienced reviewers), 1,270 reviews were completed within an average of 35 days each. In a number of "low-volume" specialties (those in which CCU has no or few trained reviewers), 486 reviews were completed within an average of 69 days each — nearly twice as long on average as the "high-volume" specialty reviews. Few disagree with the concept of improving quality by bringing greater expertise to bear, where feasible. However, MBC's implementation of the specialty reviewer requirement has introduced increased cost and substantial delay in the processing of QC cases, and the requirement does not

appear to have made a significant difference in the quality of reviews performed since January 1, 2003.

4. The codification of mandatory case processing priorities is resulting in unintended consequences. SB 1950 (Figueroa) added section 2220.05, which requires MBC to "prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously." The statute sets forth five categories of "priority cases," and CCU now tags these cases as "U1" through "U5" priority cases. Proper case prioritization is a sound public policy goal, but the codification of these priorities has caused unintended consequences that warrant exploration. Specifically, the language of the statute and the way in which MBC has implemented the section 2220.05 priorities have elevated *patient outcome* over factors which may be as or more important in enforcement circumstances, including imminence of harm, strength of evidence, and culpability. Patient injury or death is always tragic. But the mere presence of a tragic outcome should not always dictate prioritization of enforcement activity.

For example, many cases classified as U1 are section 801 reports of civil malpractice settlements, which often occur several years after the event that prompted the lawsuit, making it possibly inappropriate to classify the complaints as U1 because the physician is simply not "a danger to the public" as required in section 2220.05(a)(1). Conversely, other kinds of complaints posing serious risk of real-time harm and accompanied by strong evidence are relegated to lower status or not included at all on the priorities list. A good argument can be made that it is more important for MBC to move now on a complaint of recent egregious sexual misconduct (U4) or practicing while impaired (U5) than a section 801 report of a civil settlement involving the death of a patient five years ago (U1).

Adequate protection of the California public requires an enforcement presence in other important areas of medical misconduct. While still giving serious health harm its due significance, MBC should permit its supervisors to identify non-fatal or grievous injury cases where the immediacy of the threat, the strength of the evidence, the need for enforcement deterrence, and the prospects for effective action call for MBC to act. The intent behind section 2220.05 was undeniably good, but the priorities statute should be refined to effectuate the intent of SB 1950 (Figueroa) and the overall public protection mandate of the Board.

5. Many of MBC's most important detection mechanisms are failing it. Business and Professions Code section 800 *et seq*. sets forth an extensive "mandatory reporting scheme" intended to enable MBC to detect physician negligence, incompetence, and wrongdoing so that it might investigate and take appropriate disciplinary action. These are valuable information sources for the Board's disciplinary process, but many of them are failing the Board and the public, including:

■ ***Malpractice Payouts***. Many section 801 and 801.1 notices by insurers of malpractice payouts are not filed within the required 30-day time period, are incomplete, and/or are useless to the Board (for example, many fail to include the address or contact information of the plaintiff in the malpractice action). MBC and HQE contend that malpractice action documents required to be forwarded to MBC under section 804 are often destroyed.

■ ***Coroner's Reports***. Section 802.5 requires a coroner to file a report with MBC whenever the coroner "receives information" that a death may be the result of a physician's gross negligence or incompetence, but MBC receives few coroner's reports — never more than 40 in a given year.

■ ***Physician Self-Reporting of Criminal Convictions***. Section 802.1 limits physician self-reporting of criminal convictions to felonies, but many misdemeanor convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action. Physicians should self-report them to MBC.

■ ***Court Clerk Reporting***. Section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC, but there is a low level of compliance with these statutes by court clerks.

■ ***Hospital Reporting of Adverse Peer Review Action***. Section 805 reporting by hospitals, health care facilities, and HMOs is one of the most valuable source of complaints to MBC, and is the greatest area of failure. Compliance with section 805 is even lower than it appears: Over 500 California hospitals filed only 157 section 805 reports with MBC in 2003–04 — and one-third of those peer review actions were taken *after* MBC disciplined the physician's license. Only six disclosable section 805 reports were filed with MBC in 2003–04.

■ ***Regulatory Gag Clauses***. In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians through the inclusion of "regulatory gag clauses" in civil settlement agreements. Regulatory gag clauses should be statutorily banned for all regulated trades and professions and particularly for physicians in light of the irreparable harm doctors can cause.

6. The staffing allocations of CCU's sections should be revisited. Because CCU receives more PC than QC complaints, CCU should revisit the allocation of staffing between its QC and PC sections, and should arrange for sufficient cross-training of analysts to deal with illness, vacations, and other CCU analyst absences.

7. Detection of repeated negligent acts has improved, but could be enhanced. CCU's new procedure calls for review of prior complaint history before a QC case is closed for a "simple departure." This is beneficial and should be extended to PC matters as well.

8. Subject physicians are not always notified when complaints are closed or forwarded for investigation.

9. CCU should regularly review and update its procedure manuals.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #5: CCU should discontinue counting NOIs, NPDB reports, and "change of address citations" as complaints, and accurately report its true complaint total and average complaint processing time. CCU has already discontinued counting NOIs and NPDBs as complaints.

Recommendation #6: Code of Civil Procedure section 364.1 should be repealed. The "notices of intent" forwarded to MBC contain very little useful information, and CCU and MBC district offices now have access to the Civil Index, a more reliable record of civil actions filed.

Recommendation #7: CCU must establish a firm policy on medical records procurement, and HQE must assist CCU in enforcing that policy. MBC and HQE should stop tolerating delays, enforce existing laws, and utilize all available tools to ensure compliance with medical records laws.

Recommendation #8: MBC and HQE should expand the role of HQE attorneys in CCU. MBC and HQE should expand and fund the role of HQE in CCU in compliance with Government Code section 12529 *et seq*., and in particular, HQE should play a much greater role in medical records procurement in CCU.

Recommendation #9: CCU should revisit its implementation of the "specialty reviewer" requirement in section 2220.08. MBC's current interpretation of the statute may be unduly narrow, is causing potentially unnecessary delay in the processing of quality of care cases, and is costing the Board time, money, and the use of expert reviewers at the district office level.

Recommendation #10: Section 2220.08 should be amended to permit CCU to refer directly to the field (without specialty review) any new complaint relating to a physician who is the subject of a pending investigation, accusation, or on probation. In addition, consideration should be given to amending section 2220.08 to provide an exception to the specialty reviewer requirement where CCU is unable to locate a specialist after a 30-day good-faith search.

Recommendation #11: The Monitor and all stakeholders in MBC's enforcement program should collaborate to refine the language of section 2220.05's "mandatory case

processing priorities" to effectuate the intent of SB 1950 (Figueroa) — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

Recommendation #12: Insurers should be penalized for failure to comply with existing reporting requirements.

Recommendation #13: Misdemeanor criminal convictions should be reported to MBC.

Recommendation #14: MBC should educate coroners about their reporting requirements under section 802.5.

Recommendation #15: The Department of Consumer Affairs should join with the Judicial Council to design an educational program for courtroom clerks, judges, and public prosecutors to enhance their compliance with the reporting requirements in Business and Professions Code section 800 *et seq*.

Recommendation #16: The study of peer review authorized in SB 16 (Figueroa) should be funded and conducted as soon as possible.

Recommendation #17: MBC's sunset legislation should include a provision banning the inclusion of regulatory gag clauses by licensees of any agency created in Division 2 of the Business and Professions Code.

Recommendation #18: CCU should revisit the staffing allocations of its two sections, and MBC should consider augmenting the staff of this important unit so its analysts are not overburdened with excessive caseloads and to accommodate the cross-training of analysts.

Recommendation #19: CCU should institute a review process for "simple departures" in PC cases — especially in complaints alleging sexual misconduct and drug/alcohol offenses — to ensure that it is not overlooking potential investigations and prosecutions of repeat offenders.

Recommendation #20: CCU should ensure that subject physicians are notified when complaints are closed or forwarded for investigation.

Recommendation #21: CCU should ensure that its policy and procedure manuals are regularly updated to accommodate changes in the law, MBC policy, and CCU structure.

FIELD INVESTIGATIONS: DISTRICT OFFICES

A. General Description of Functions

Complaints and reports about California physicians which have passed through the screening process of the Central Complaint Unit are referred to MBC's district offices for investigation. MBC maintains twelve field offices ("district offices") staffed by peace officer investigators, supervising investigators, and medical consultants (physician employees). A complaint that warrants additional scrutiny after CCU screening is referred the district office in the geographical area where the subject physician practices. The case is assigned to an MBC investigator who — assisted by the medical consultant, supervising investigator, and an HQE attorney — reviews the existing file and conducts the investigation, including the gathering of medical records or evidence; locating and interviewing complainants and other witnesses; interviewing the subject physician; and in quality of care cases securing review of the investigative report and the evidence by a physician "expert reviewer." In 2003–04, Medical Board investigators opened 1,887 investigations, closed 2,117 investigations, referred 580 matters to HQE for administrative enforcement action, and referred 37 cases for criminal action.

Chapter VII provides a detailed description of the district offices' role in the current investigative process; the district offices' structure and declining resources; the role of the Attorney General in the investigative process (including the limited advisory role of the Deputy in District Office program); the role of medical consultants in the investigative process; and statutory timeframes for MBC investigations.

B. Initial Concerns of the MBC Enforcement Monitor

1. MBC investigations are plagued by delays and excessive case cycle times. The Medical Board has consistently failed to comply with the statutory goals set by the Legislature for the investigative process, including an average of six months total time to completion of investigation (one year for complex matters). The average elapsed time for an MBC investigation is now 261 days, up from a similarly-calculated 243 days in 2002–03, and fully 27% take an average of 15 months (or 2.5 times the state's goal). Multiple personnel and process issues contribute to these long cycle times (many beyond the control of district office staff), including the general difficulty of MBC cases; reductions in district office staff; losses of other valuable resources (such as medical consultant time); investigator recruitment and retention challenges; a changed case mix toward greater complexity; and increased defense counsel use by physicians.

MBC's cadre of investigators are competent and dedicated, and they are doing a good job of maintaining the volume and quality of casework despite challenges. However, even with MBC

investigator caseloads at record lows (presently 18 cases per investigator), there is persistent noncompliance with the six-month processing goal, and case cycle times are again trending upward. Despite good efforts, MBC investigations take too long and suffer many avoidable delays, which result from a pervasive "hurry up and wait" phenomenon, in which investigators must wait to get complete medical records (an average of 74 days, despite the 15-day period in state law and CCU's prior expenditure of 66 days to obtain records in QC cases); wait for the medical consultant to assist; wait for the subject to agree to be interviewed (an average of 60 days); wait for the medical consultant's memo and identification of the essential expert reviewer; and wait for the expert review (an average of 69 days — over twice MBC's goal). Successfully addressing the causes of these lengthy built-in delays will significantly reduce the stubbornly long case cycle times in MBC investigations.

2. Attorney/investigator coordination and teamwork is inadequate. Notwithstanding dedicated work by MBC and HQE staff, the current system linking MBC investigators and HQE prosecutors suffers from inadequate coordination and teamwork. MBC investigators generally function without true, close coordination with the trial prosecutor who will ultimately handle the case. Despite the good intentions underlying the DIDO program, most MBC investigators still receive only limited legal support for their investigative work; they rarely work directly with assigned trial counsel during the critical formative phases of the case; and they seldom play a significant role in the pre-hearing and hearing process to which their work is directed. This system of limited investigator/trial attorney joint work and cooperation is typical of the "hand-off prosecution model" best suited to simple street crime prosecutions. MBC's hand-off model stands in sharp contrast to the "vertical prosecution model" widely used in complex white collar crime and regulatory matters.

Current MBC/HQE "hand-off prosecution" process. The current enforcement process at MBC involves (1) an investigator with limited legal guidance and support investigating a case, preparing the file, and "handing off" or transmitting the case to (2) an HQE attorney who has had no role in the shaping or preparation of the case and must function with little or no investigative support in the pre-hearing and hearing process. This "hand-off" system is woefully inadequate for complex white collar crime-type cases of the sort usually handled by MBC — where the subject is highly technical, the facts and legal issues are complicated, and the process requires a lengthy commitment of time and enthusiasm to achieve a sound result.

This MBC "hand-off" investigation/prosecution process has long been criticized as inadequate and inefficient. The DIDO program, formally undertaken in 1997, has provided limited legal advice and assistance for district office investigators. But it is a halfway measure which has produced inconsistent and partial results, ranging from useful assistance to little benefit, and has never accomplished the desired integration of investigators and prosecutors into a closely-knit and effective

team. Even under the DIDO program, the current investigator/attorney relationship has serious limitations and weaknesses, including inadequate communication and coordination; unclear and frustrating working relationships; no joint investigative plan; inadequate follow-up and assistance for the prosecutor at trial; reduced commitment to cases; and missed training opportunities.

The vertical prosecution model. In many — and perhaps most — other law enforcement agencies involved in complex matters, prosecutors and investigators work together in teams from the day a case is assigned for investigation, in a process known as the "vertical prosecution model" for enforcement actions. The vertical prosecution model is based on the realization that this process is an inherently *legal* one: The purpose of these complex investigations is to *prepare cases for trial* or other legal disposition — a function which requires legal input and which benefits from having that guidance and assistance from its inception.

Under this model, the trial attorney and the investigator are assigned as the team to handle a complex case as soon as it is opened as a formal investigation. In this system the prosecutor and the investigator work together during the investigative phase to develop the investigative plan and ensure the gathering of necessary evidence to prove the elements of the offense and to address anticipated legal defenses; provide legal analysis of the incoming evidence to help shape the direction of the case; prepare subpoenas or help secure search warrants to prod uncooperative subjects or third-party witnesses; deal directly with defense attorneys when issues arise; and address settlement or plea matters, which often appear early in such cases. In turn, the investigator contributes a peace officer's experience and insight into the investigative plan and case strategy, and performs the field investigative tasks.

A number of different organizational structures or formats can be used to achieve the benefits of vertical prosecution. However, the essential elements of any such model are early coordination of the efforts of attorneys, investigators, and other staff; continuity of teamwork throughout the life of a case; mutual respect for the importance of the professional contributions of both attorneys and investigators; and early designation of trial counsel.

The precise implementation of these essential elements is flexible. For example, this model is generally best implemented by an organizational structure where the attorney and investigator staff are employees of the same agency. This approach can also succeed where the team members work for different organizations.

Precedents for the vertical prosecution model at other agencies are plentiful, including federal agencies (including the U.S. Department of Justice's Antitrust Division and the Federal Trade Commission), state agencies (including successful implementation of the vertical prosecution model at the State Bar of California, as well as the California Department of Justice's Medi-Cal Fraud

Section, the Special Prosecutions Unit, and Major Fraud Section) and local agencies (more than 40 of the 58 district attorneys' offices in California maintain specialty consumer protection, major fraud, and environmental law sections, and *all* of these prosecution units work with in-house investigators in a vertical prosecution format).

Application of the vertical prosecution model to MBC. Applied to MBC, the benefits of vertical prosecution would be numerous and substantial: (1) improved efficiency and effectiveness arising from better communication and coordination of efforts; (2) reduced case cycle times; (3) improved commitment to cases; (4) improved morale, recruitment, and retention of experienced prosecutors and investigators; (5) improved training for investigators and prosecutors; and (6) the potential for improved perception of the fairness of the process.

3. Delays in medical records procurement are chronic. The lengthy waiting time for the procurement of essential medical records is among the greatest problems facing MBC's district offices and among the principal sources of overall case processing delays. Medical Board staff report that in fiscal year 2003–04, the average timeframe from a request for records by MBC investigators to receipt of all records was 74 days (or 2.5 months), despite the statutory 15-day timeframe in Business and Professions Code sections 2225 and 2225.5. Combining investigations' 74-day average with CCU's average 66-day records-gathering period, medical records procurement at MBC consumes an average of 140 days — or 77% of the 180-day goal in section 2319. Both MBC investigators and HQE prosecutors demonstrate apparent tolerance for physicians' lengthy delays in complying with medical records requests. Requests for assistance to HQE by either CCU staff or district office investigators are comparatively infrequent, and actual enforcement actions are even less frequent.

Alternatives to the present practice have been utilized periodically or may be available for use, including firm compliance deadlines, prompt use of subpoena enforcement and sanctions actions, warrantless searches (where patient releases have been obtained), and other measures. However, these tactics have until now represented extremely rare exceptions to the usual records procurement process.

4. Subject interview policies are inconsistent and ineffective. Medical Board investigators must conduct subject interviews as a key part of the district office investigative process. The current average time between initial request and actual subject interview is 60 days for the district offices as a whole, which represents a large portion of the typical nine-month investigative timeframe. Contributing to this delay is inconsistency among district offices regarding the use and conduct of these subject interviews. Some investigators rely on persuasion; others pursue a strict policy enforcing these procedures. The more permissive policy of informal persuasion, voluntary requests, and waiting for cooperation contributes significantly to the problem of excessive case cycle

times. The prompt use of the administrative subpoena authority, after a reasonable interval for cooperation, has worked well in certain district offices and should be implemented statewide. Similarly, sound public policy calls for subject interview tape-recording in most if not all circumstances today. To the extent that current subpoena authority, or authority to record interviews, is perceived as unclear, statutory changes to clarify the specific authority of the Medical Board, and to require physician cooperation as function of professional responsibility, may be appropriate.

5. Medical consultant availability, training, and utilization are inadequate. Problems of medical consultant availability, training, and proper use contribute significantly to lengthy investigations and inefficient operations. Budget constraints have caused a 15% reduction in available consultant hours agency-wide in 2003–04. These reductions made it more difficult to obtain required medical consultant assistance, exacerbating a situation of reduced investigative and support staff, and requiring unproductive down time in cases waiting for consultant attention. In particular, these reductions often mean that medical consultants are unavailable for or greatly delayed in reviewing expert opinions and participating in the decision to transmit cases. Some offices report that this function is hardly performed at all by assigned consultants. This aspect of the medical consultant's function is among the most important of all, and is central to the speed and quality of QC case processing. Other concerns about medical consultant practices merit the attention of the Medical Board: (1) medical consultants may have inadequate information about prior complaints and inquiries in order to identify patterns of misconduct by subject physicians; (2) medical consultants need to play an even greater role in the identification and recruitment of physicians to serve as expert reviewers; and (3) medical consultant training is inadequate.

6. Expert witness availability and use are systemic weaknesses. Investigators lament the unavailability of experts, especially in highly specialized fields, the inadequacy of training provided to experts, and the inconsistent performance and uses made of these experts. These concerns are addressed in detail in the "Expert Reviewer Program" section below.

7. Ongoing training of investigators, medical consultants, and experts is inadequate. MBC, which in years past has had an exemplary training program in place, has substantially reduced formal training for investigators, medical consultants, experts, and others, as an accommodation to pressing budgetary concerns. If MBC is to significantly improve its case cycle times and efficiency, a systematic and professionalized training program for its field investigators, medical consultants, and expert reviewers is required.

8. Coordination with state and local prosecutors is underutilized. Many of MBC's peace officer investigators have substantial knowledge of the criminal and civil law enforcement options available to the agency as potential tools to address complaints against medical practitioners involving both quality of care and physician conduct issues. However, prosecutors throughout the

state cite the inadequacy of early communication or consistent coordination between MBC investigators and state and local law enforcement agencies in cases where non-administrative enforcement tools (such as Penal Code section 23 probation orders or civil unfair competition actions) may be appropriate.

9. Recruitment and retention problems exacerbate MBC personnel shortages. Recruitment and retention problems plague personnel management at the Medical Board. Supervisors and field investigators uniformly report that valuable, experienced investigators are lost and well-qualified applicants go elsewhere because of salary disparities between the pay of the MBC and other agencies hiring peace officers. MBC regularly loses in competition with other agencies over highly qualified investigative personnel.

10. Procedural and training manuals must be updated continuously. MBC investigations and other enforcement processes are today guided by policy and procedure manuals which in most cases have not been consistently reviewed or approved by HQE — MBC's legal counsel and principal partner in enforcement. In addition, at least some of these manuals have not been updated adequately by MBC management and thus are sufficiently outdated to be inaccurate as to Board policy.

11. Investigators need full and easy access to all law enforcement databases and to appropriate commercial databases. MBC investigators complain of inconvenient access to the law enforcement databases which are essential to modern police work, and budgetary limitations which prevent them from using commercial databases, such as Merlin, Westlaw/Dialog, and similar systems, which investigators in other California agencies are funded and permitted to use.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #22: MBC and HQE should fully implement the vertical prosecution model. MBC investigators and HQE prosecutors should work together in a true vertical prosecution system featuring case teams established at the initiation of the investigation and remaining together until the case is fully litigated or resolved. The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE; however, the model could also be implemented within other organizational arrangements.

Recommendation # 23: MBC and HQE must revise their medical records procurement and enforcement policy to ensure prompt and full compliance with existing law. As discussed in related Recommendation #7, MBC and HQE should adopt and strictly enforce a comprehensive medical records procurement policy which is consistently applied in all MBC enforcement cases. This policy should involve strict deadlines and prompt use of subpoena enforcement and sanctions

actions. MBC and HQE should also consider: (1) formation of a small "strike team" of prosecutors familiar with and skilled in subpoena preparation and enforcement actions; (2) clarifying or strengthening, as needed, the professional obligation of California physicians to comply with lawful MBC requests for medical records; (3) the joint development of MBC/HQE protocols for the proper use of warrantless searches (where patient releases have been obtained) and for the use of Code of Civil Procedure section 1822.5 administrative inspection warrants in appropriate cases; and (4) a statutory amendment to shift attorney's fees to the investigation subjects when MBC and HQE prevail in subpoena enforcement actions.

Recommendation #24: MBC should develop and enforce a consistent new policy on physician interviews. Physician interviews should proceed in a prompt and orderly sequence of requests, subpoenas, and enforcement, as needed, with appropriate consideration given to legislation requiring subject physicians to appear at interviews upon reasonable notice, requiring tape-recording, and clarifying the duty of licensees to cooperate with MBC disciplinary inquiries.

Recommendation #25: MBC should improve cooperation and case referrals between its enforcement staff and state and local prosecutors involved in criminal and civil prosecutions.

Recommendation # 26: MBC should continue its efforts to restore lost investigative resources to provide staff for special projects and major case response teams. Reinstatement of lost investigator positions should be sought to enable MBC to undertake proactive and undercover operations, such as the Operation Safe Medicine and the Internet Crimes Unit, and to support the formation of two rapid response teams to handle major cases of unusual complexity and emergency matters with potential for serious health or safety consequences.

Recommendation #27: MBC should improve and regularize investigator training, and update all enforcement program procedure manuals.

Recommendation #28: MBC should expand and improve the medical consultant program. Medical consultant hours should be increased, at least to restore the 15% reduction suffered in the fiscal year 2003–04 budget, and preferably to add a similar incremental increase to permit substantially increased consultant assistance, especially in the review of expert reviewer opinions and contributions to the decision to transmit a case. Medical consultants should also assist in recruiting and training expert reviewers.

Recommendation #29: MBC should improve investigator access to law enforcement information systems.

EXPERT REVIEWER PROGRAM

A. General Description of Functions

In quality of care disciplinary matters against a physician, expert opinion testimony is required to prove or disprove that the physician performed in accordance with the prevailing standard of care. Because the burden of proof is on the Board, it must produce one or more physician witnesses with experience and expertise in the specialty or procedure at issue. That expert witness must review all the evidence in the case, testify to the standard of care applicable to each procedure performed, opine as to whether the subject physician's conduct departed from that standard of care and to what degree, and explain the justification or basis for his opinion. This burden requires MBC to recruit, train, and select expert witnesses who are willing to review disciplinary investigations against other physicians, write detailed memoranda and opinions, and — if necessary — testify orally at an evidentiary hearing. To enable expert review of QC cases, MBC created an "Expert Reviewer Program" in 1994 and has since recruited and trained a list of over 750 expert reviewers in all specialties throughout the state.

Chapter VIII details MBC's appointment process and minimum qualifications for its expert reviewers; the ways in which MBC recruits experts; the method by which district office investigators and medical consultants select an expert for any given QC matter; the payment and immunity from civil liability afforded to MBC expert reviewers; and the experts' feedback to MBC on the quality of their experience as an expert reviewer.

B. Initial Concerns of the MBC Enforcement Monitor

1. Average expert reviewer cycle times are excessive. MBC instructs its experts to review medical records and other materials and submit an expert opinion within 30 days. However, the average turnaround time for expert opinions is 69 days — over two times its goal. Further, MCs and investigators note that the 69-day timeframe discussed above does not include the time it takes them to simply locate a qualified reviewer.

2. There is a lack of qualified experts in many specialties, and the CCU specialty reviewer requirement is siphoning off some experts who would otherwise review cases in the field. Despite MBC's recruitment efforts, there are not always a sufficient number of qualified experts in high-demand specialties and subspecialties willing to work for $100 per hour. This leads to delay in locating qualified experts and in the use of "off-the-list" experts on some occasions. Further, section 2220.08's requirement that "specialty reviewers" evaluate quality of care complaints in CCU has led CCU to "borrow" experts from the Expert Reviewer Program's list. This costs MBC more money (because experts on the Expert Reviewer Program list are paid more than are CCU

experts, and because experts often do more work than is necessary at the CCU stage) and deprives MBC field offices of using those physicians as expert reviewers for completed investigations.

3. There is no requirement that expert testimony be reduced to writing and/or exchanged before hearing. MBC requires its experts to reduce their expert opinions to writing — and those expert opinions are immediately discoverable by the defense. However, defense counsel frequently instruct their experts not to reduce their opinions to writing so the HQE DAG has no idea of the substance of defense counsel's expert opinion until that expert takes the stand at the evidentiary hearing. This practice results in the unfair "sandbagging" of the DAG at the hearing, and stifles the possibility of prehearing settlement. Litigation surprise regarding this central element of the administrative action is costly to the respondent and MBC, unfair to the DAG, and disserves all parties to the process and the public interest as a whole.

4. The expert reviewer handbook contained errors. The *Individual Study Program for Expert Reviewers* provided to the Monitor in 2003 was last updated in October 2002, and did not appear to have been revised to conform to the changes made by SB 1950 (Figueroa). It contained a significant error regarding the definition of "repeated negligent acts" and other lesser errors. The manual has been reviewed by HQE and the errors have been corrected.

C. Initial Recommendations of the MBC Enforcement Monitor

<u>Recommendation #30</u>: The Medical Practice Act should be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the hearing. The exchange of expert witness opinions prior to hearing will lead to more settlements and will remove the current and unfair "sandbagging" of the DAG at hearings on most occasions.

<u>Recommendation #31</u>: MBC should make better use of its district office medical consultants, existing expert witnesses, Board members, and the California Medical Association to recruit more expert reviewers. MBC clearly needs more qualified experts who have time to devote to reviewing MBC cases and returning expert opinions in a timely manner. Once its medical consultant hours are restored, the Board should make better use of its district office medical consultants to aggressively recruit expert reviewers in their local communities. Additionally, it should attempt to utilize its existing expert witnesses, Board members, and CMA to assist in recruiting more expert reviewers.

<u>Recommendation #32</u>: MBC should consider paying its experts more, and resume in-person training sessions for its experts. Although physicians who serve MBC as expert witness clearly aren't in it for the money, 49% of the experts who returned MBC's survey said they weren't

paid enough for their services. Defense experts are routinely paid $500–$750 per hour, and MBC simply cannot compete for the best experts at $100 per hour. If MBC's budget change proposal is approved, MBC should consider increasing its expert witness fees, and a resumption of local, in-person training sessions for expert witnesses conducted by district office supervisors and medical consultants.

PROSECUTIONS: HEALTH QUALITY ENFORCEMENT SECTION

A. General Description of Functions

After a Medical Board district office has completed an investigation yielding sufficient evidence of chargeable physician misconduct, the case is transmitted to the Attorney General's Health Quality Enforcement (HQE) Section for administrative action, or to the appropriate state or local prosecutor for criminal or civil law enforcement action. Under Government Code section 12529 *et seq*., HQE is responsible for prosecuting disciplinary proceedings against MBC licensees; in addition, it is charged with assisting MBC with complaint intake and investigation activities in support of those prosecutions. To implement its responsibility to assist with investigations, HQE created the Deputy in District Office (DIDO) program in 1997. To implement its responsibility to assist with complaint intake, HQE formally assigned a deputy attorney general to CCU on October 1, 2003.

HQE is staffed by a Senior Assistant Attorney General, six Supervising Deputies Attorney General (SDAGs), and 36 deputies attorney general (DAGs) stationed in six offices across the state. In 2003–04, HQE received 580 cases transmitted from MBC investigators (up about 15% from the prior year, but on par with the three-year average of preceding years), filed 262 accusations (down from a 2001–02 high of 329 but about average for the past five years), obtained 48 prefiling stipulations and 202 postfiling stipulations, and conducted 45 administrative hearings.

Chapter IX provides a detailed description of HQE's role in the current enforcement process; HQE's structure and resources; Attorney General/HQE management information systems; HQE enforcement outputs; and HQE case cycle times.

B. Initial Concerns of the MBC Enforcement Monitor

1. HQE cycle times remain lengthy, including recent increases in the filing phase. Despite the presence of a cadre of experienced DAGs, many of whom are highly skilled and motivated, HQE remains burdened with lengthy case processing times. In particular, HQE is experiencing rapid erosion of earlier progress in the filing phase — the one aspect over which the Attorney General has primary (although not exclusive) control. MBC statistics now show an average

107-day period between transmittal of the case by MBC and the filing of the accusation, which converts a confidential investigation into a matter of public record. HQE's understaffed Los Angeles office averages more than five months to the filing of pleadings. HQE management uses different statistical definitions and reports shorter filing times, but readily acknowledges that average time to file pleadings has doubled in the past three years, an increase HQE attributes primarily to reductions in attorney staff.

2. HQE attorney staffing is insufficient to meet its statutory and operational requirements. HQE's six offices have suffered a 15% loss of staff positions in the past three years, with the greatest impact felt in the Los Angeles office. Senior managers presently contend that HQE does not have "a sufficient number of experienced and able [DAGs]" to meet the statutory mandate of Government Code section 12529, especially in HQE's Los Angeles office as a function of the loss of six DAG positions since early 2002. The overall HQE staffing picture is similar: inadequate DAG staff to move all MBC cases rapidly to conclusion. Reduced staffing in key locations (most critically in the Los Angeles office) has resulted in unacceptable delays in case pleading and litigation, and insufficient opportunities for remaining DAG and SDAG staff to engage in training and mentoring of newer attorneys.

3. Attorney/investigator coordination and teamwork is inadequate. Notwithstanding good faith efforts, the current system linking HQE prosecutors with MBC investigators is characterized by inadequate coordination and teamwork. HQE prosecutors generally receive "hand-off" cases which have been investigated and assembled with little or no input whatsoever from the HQE trial prosecutor who will handle the case. Although the DIDO program has provided a varying measure of additional HQE legal input into the investigative process, most HQE prosecutors still complain that they do not play a role in shaping the cases they receive or the investigative plans and strategies behind them, leading to frequent problems of late changes in case focus, amended pleadings, and lengthy delays while cases are re-evaluated and re-investigated. Complex medical cases continue to evolve as the litigation develops, and HQE DAGs today do not have significant investigator assistance with crucial follow-up or adequate assistance from the investigating officer during the pre-hearing and hearing process.

The principal discussion of the present HQE and MBC case coordination relationship is found above in the "Field Investigations: District Offices" section of this Executive Summary, and that section is incorporated here.

The DIDO compromise and the vertical prosecution alternative. From the perspective of the trial attorneys in HQE assigned to try these cases, it is clear that the Legislature's compromise on the preferred vertical prosecution model proposed in 1990, which is codified in Government Code section 12529, offers at least some of the benefits of vertical prosecution, but has not produced the

true teamwork system required for optimal efficiency and effectiveness. The DIDO program is certainly better than the prior "hand-off" situation in which investigators lacking any legal guidance whatsoever were investigating cases and handing them off to a prosecutor who lacked any investigative assistance and who had no role in guiding the investigation prior to the "hand-off."

However, DIDO has many flaws and has not yielded the benefits a true vertical prosecution system would provide. The present DIDO program is widely perceived as inefficient and even a wasteful use of the DIDO DAG's time, coming as it does at the cost of depriving HQE of a line prosecutor without creating a true case team. And HQE personnel correctly perceive that DIDO is not implemented uniformly throughout the state. And this only worsens the existing measure of confusion among HQE attorneys and MBC investigators and supervisors as to the chain of command and the roles of the participants.

HQE attorneys agree that the DIDO program does not enable the trial attorney to invest in a case from the first day or guide its investigation, and thus most of the efficiencies and advantages of a true team approach to this casework are lost. The overwhelming consensus among HQE attorneys and supervisors favors the full implementation of the vertical prosecution model in which an attorney/investigator team is formed at the inception of an investigation and works together to the case's conclusion.

4. Attorney assistance is not used sufficiently in MBC's medical records procurement process. HQE prosecutors are seldom used for subpoena enforcement actions and most DAGs make little or no use of section 2225.5 sanctions for failure to produce medical records, notwithstanding strong statutory authority and supporting case law. As a result of this infrequent use of these enforcement tools, doctors and their lawyers pay little attention to section 2225.5 sanctions because they are generally aware of the infrequent enforcement of these sanctions, and because the potential sanctions exposure is comparatively modest in light of most doctors' incomes. Serious delays in medical records procurement are pervasive in the 1800-plus investigations handled each year, making it difficult to understand how the modest level of subpoena enforcement and sanctions actions is sufficient to address this problem each year.

5. HQE and MBC make inadequate use of their ISO/TRO powers and the Penal Code section 23 authority. When MBC identifies a physician who is an imminent danger to the public if he continues to practice medicine, it is authorized to seek interim remedies to protect the public, including interim suspension orders (ISOs), temporary restraining orders (TROs), and probation order proceedings under Penal Code section 23. MBC's enforcement output statistics indicate a troubling decline in the efforts to use the powerful ISO/TRO authority in the recent past. ISOs/TROs sought by HQE on behalf of the Medical Board diminished from a high of 40 in 2001–2002 to 26 in the 2003–04 fiscal year (a decline of 40%). Given the importance of these public safety circumstances, a decline in the use of these tools is a source of concern to the Monitor.

6. Needed improvements in HQE case tracking and management information systems have begun and must be properly implemented. The Attorney General's Office as a whole has long been subject to criticism for its outdated and antiquated management information system. To address these concerns, the Attorney General has installed the long-awaited ProLaw management information system. Implementation of ProLaw is still in its gestational stage, and at this early point even the staff of the Attorney General's Office is unclear as to what kind of management reports it can produce and/or what kind of information they must input in order to generate those reports. At the very least, there is a clear consensus that this long-overdue update to the AG's management information system is necessary and must be fully implemented.

7. HQE has no formal policy and procedure manual to ensure uniformity and assist in training. HQE presently has no formal policy and procedure or operations manual in place regarding its functions and process. This leads to diverging policies and inconsistencies among HQE offices. In addition, most training in HQE for new DAGs appears to be infrequent and informal, with the majority of the guidance provided by SDAGs and more experienced HQE staff on an *ad hoc* and verbal basis as questions arise. Anticipated loss of institutional memory and practical trial experience could be compensated for, to at least some extent, by a properly drafted policy and procedure manual which preserves the benefits of that experience.

8. The current venue statute for adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC, and — ultimately — disciplined physicians and the physician population generally. Government Code section 11508 generally assigns the venue for administrative hearings to the judicial district in which the transaction in question occurred or where the respondent resides. This statute frequently requires the costly scheduling of administrative hearings in cities in which HQE and OAH have no office facilities. Requiring adjudicative hearings to be held in cities in which HQE and OAH already have office facilities will substantially lessen costs for MBC, and in many cases for the respondent as well.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #33: MBC and HQE should fully implement the vertical prosecution model. As described in related Recommendation #22 above, full implementation of the vertical prosecution model — in which an attorney/investigator team is formed at the inception of an investigation and works together to the case's conclusion — would greatly improve the efficiency and effectiveness of HQE's prosecution efforts and MBC's enforcement process as a whole. The Monitor believes the vertical prosecution system could best be implemented by merging existing MBC investigators and supervisors into HQE. However, this system could be otherwise effectuated through coordinated assignments to case teams by the respective agencies.

Recommendation #34: MBC and HQE must revise their medical records procurement and enforcement policy to ensure prompt and full compliance with existing laws, and the role of HQE attorneys in medical records procurement issues should be expanded. As described in related Recommendations #7 and #23, HQE and MBC should adopt and strictly enforce a comprehensive medical records procurement policy which is consistently applied in all MBC enforcement cases.

Recommendation # 35: The Attorney General's Office should come into full compliance with Government Code section 12529 *et seq*. by adequately staffing HQE to restore lost attorney positions and to fulfill all missions required by these statutes.

Recommendation #36: MBC and HQE should improve their cooperation with state and local prosecutors, including increased use of Penal Code section 23.

Recommendation #37: MBC and HQE should make better and more extensive use of the powerful interim suspension order and temporary restraining order tools.

Recommendation #38: HQE should develop a formal policy and procedure manual to improve consistency and assist in prosecutor training.

Recommendation #39: Government Code section 11508 should be amended to locate venue for HQE administrative hearings in the cities of Sacramento, Oakland, Los Angeles, and San Diego. The statutory presumption should be that these hearings are to take place in large-city locations in which HQE and OAH already have offices.

HEARINGS: MEDICAL QUALITY HEARING PANEL

A. General Description of Functions

The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state agency adjudicative hearings in a variety of areas. OAH currently employs a director, four presiding judges, and 34.4 ALJs based in four California cities (Sacramento, Oakland, Los Angeles, and San Diego). A special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH in 1990's SB 2375 and refined in 1993's SB 916. The purpose of the creation of the MQHP is to enhance the expertise and independence of the ALJs who preside over physician discipline hearings. MQHP ALJs specialize in physician discipline matters, may be required to have medical training, and are afforded assistance by panels of independent experts who may be called as witnesses by the ALJ to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all parties. MQHP ALJs are

authorized to entertain motions for and issue interim suspension orders restricting or suspending the license of a physician pending the conclusion of the disciplinary matter, as an alternative to the temporary restraining order remedy in superior court.

Evidentiary hearings on accusations filed by MBC are presided over by an MQHP ALJ. During the hearing, each party has the right to examine and cross-examine witnesses, present documentary evidence, and present oral argument. Following submission of the evidence, the ALJ prepares a written decision including findings of fact, conclusions of law, and recommended discipline. At the Board's request, the ALJ may also recommend that the licensee pay "cost recovery" to reimburse the Board for its investigative and enforcement costs incurred up to the first day of the evidentiary hearing. The ALJ's ruling is a "proposed decision" which is forwarded to the Division of Medical Quality (DMQ), which makes the final agency decision. In recommending discipline, the MQHP ALJ is guided by a set of "disciplinary guidelines" approved by DMQ; these guidelines set forth the Division's preferred range of sanctions for every given violation of the Medical Practice Act and the Board's regulations.

B. Initial Concerns of the MBC Enforcement Monitor

Due in part to the 2003 Administration change (and an April 1, 2004 change in leadership at OAH) and in part to the press of other issues that we were required to address in this report, the Monitor did not examine OAH's performance in-depth during the first year of this project. During the second year, we plan to look at the following issues.

1. OAH was impacted by the hiring freeze and budget cuts. OAH was not immune from the October 2001 hiring freeze or the subsequent position "sweeps" and budget cuts. OAH lost two ALJ positions and a number of support staff positions. The OAH Director has stated that these losses have not directly impacted the MQHP, but they have affected the office as a whole. OAH has requested eight new ALJ positions and four support staff positions.

2. The time it takes to schedule and conduct evidentiary hearings is lengthy. An average period of 443 days passes between filing of the accusation and conclusion of the evidentiary hearing — over 14 months. Some of these hearings are one- or two-day matters; others should last weeks but — due to the schedules of the attorneys, respondent, and judge — must be conducted in many non-contiguous blocks over the course of many months. Based on a limited review, it seems that the delay in scheduling and conducting MBC hearings is not due to a shortage of judges or bureaucratic limitations on OAH's part. Instead, it appears that understaffing in HQE's Los Angeles office (which normally files approximately 60% of all accusations in California) and the limited number of defense counsel who regularly defend physicians in MBC disciplinary matters account for much of the delay in scheduling and holding hearings. In OAH's view, it has sufficient MQHP

ALJs to hear cases more rapidly than they are being heard — but they can't, due to a shortage of attorneys in HQE and the limited number of defense attorneys who handle MBC cases.

3. DMQ members perceive that MQHP ALJs are not following MBC disciplinary guidelines. During 2001–02 and 2002–03, DMQ nonadopted an unusually high number of proposed ALJ decisions: 25% in 2001–02 and 28% in 2002–03. Some DMQ members perceive that MQHP ALJs do not follow the Board's disciplinary guidelines when imposing discipline in physician cases. Although the percentage of nonadoptions declined to 16% in 2003–04, the Monitor will attempt to examine whether ALJs are adhering to MBC's disciplinary guidelines.

4. Whether ALJs are receiving medical training as authorized by Government Code section 11371 is unclear. As noted above, one of the ways in which SB 2375 (Presley) and SB 916 (Presley) sought to enhance the expertise of MQHP ALJs was to provide them with medical training "as recommended by the Division of Medical Quality . . . and approved by the Director of the Office of Administrative Hearings." It is unclear whether ALJs are receiving medical training.

C. Initial Recommendations of the MBC Enforcement Monitor

As noted above, the Monitor did not examine OAH extensively during the first year of this project. The Monitor intends to look into the above-described issues and others during the second year of the project, and report on OAH in the next report.

DECISIONS: DIVISION OF MEDICAL QUALITY

A. General Description of Functions

The Medical Board's Division of Medical Quality (DMQ), which consists of fourteen of MBC's 21 members (eight physicians and six public members), is the Board's enforcement arm. DMQ adopts final adjudicative decisions in disciplinary matters against its licensees. Adjudicative or "quasijudicial" decisionmaking, which generally governed by the Administrative Procedure Act (APA), differs fundamentally from all other types of agency decisionmaking. The courts and Legislature have adopted special rules to ensure that the due process rights of the respondent — who stands to lose a vested constitutional property right — are preserved. Of critical importance, the respondent is also entitled to a decisionmaker who is neutral and unbiased, and who decides the matter based upon evidence that has been lawfully gathered and admitted at a public hearing.

DMQ is the final decisionmaker in all MBC disciplinary matters in which an accusation has been filed. However, DMQ does not personally preside over or even attend APA evidentiary hearings; that responsibility is delegated to an administrative law judge (ALJ) from the Office of

Administrative Hearings' Medical Quality Hearing Panel (MQHP), who presides over the hearing and prepares a proposed decision (PD) for DMQ's review. Nor does DMQ negotiate the terms of stipulated settlements that avoid an evidentiary hearing; that responsibility is delegated to its counsel (HQE) and its staff, who negotiate proposed settlements with the respondent and his/her counsel and present them to DMQ for review. DMQ reviews all proposed case dispositions that follow the filing of an accusation — including all PDs (including ALJ recommendations that an accusation be dismissed), stipulated settlements, license surrenders, and default judgments. In APA jargon, DMQ is authorized to "adopt" or "nonadopt" proposed case dispositions; in so doing, it is the final judge in the disciplinary matter. It makes the final agency decision which is then subject to judicial review. It is also authorized to reconsider its own decisions before they become effective, either on its own motion or upon a petition filed by one of the parties.

DMQ panels review and act upon an average total of 54 PDs and 195 stipulated settlements each year. DMQ adopts most PDs (84% in 2003–04) and approves most stipulations (95% in 2003–04). The Division reviews and acts on approximately 20 petitions for reconsideration each year. In 2003–04, DMQ reviewed and reached a final decision on most PDs within 30 days (with the exception of the cases it nonadopted).

B. Initial Concerns of the MBC Enforcement Monitor

1. The added value of DMQ review of proposed decisions is unclear. In 1989, *Code Blue* argued that DMQ review of proposed decisions should be eliminated in favor of permitting the ALJ to make the final agency decision based on the agency's disciplinary guidelines and subject to a petition for judicial review by either side. Legislation to implement this concept was unsuccessfully attempted in 1989, 1990, and 1993. The prior attempts to eliminate DMQ review of proposed decisions were intended to achieve two goals: (1) streamline the decisionmaking process to expedite it for the benefit of both the respondent and the public; and (2) create a limited number of decisionmakers who have both subject matter expertise and independence from the profession — as opposed to perpetuating a time-consuming and expensive system with layer after layer after layer of decisionmakers who are sequentially required to learn the details of a disciplinary matter. These twin touchstones — subject matter expertise and independence — have formed the foundation of prior proposals to permit the administrative judge who has presided over the hearing to make the final agency decision (subject to a petition for judicial review by either side).

DMQ panel members who are reviewing a proposed decision in an adjudicative matter have only the proposed decision. They have no access to the evidence presented at the hearing, including expert testimony. They were not present at the hearing and had no opportunity to observe the witnesses, their credibility and demeanor, or the evidence. They are not judges and generally have no familiarity with the rules of evidence or administrative procedure. They may not have any

familiarity with the subject matter of the particular case, usually have no idea how similar cases have been decided, and usually consist in majority of people in the same profession or trade as the accused licensee. While some DMQ members may have medical expertise, it is not always "on point" expertise relevant to the specialty at issue. And the fact that many DMQ members are physicians judging other physicians leaves MBC open to a "perception" criticism that some of its members may empathize with the respondent.

In contrast, the judge was at the hearing and has seen and heard the witnesses, received all the documentary evidence, and heard the expert testimony submitted by both sides. The judge specializes in physician discipline matters and is familiar with the rules of procedure and evidence in administrative proceedings. The judge has both knowledge of the evidence and is independent of the profession — the twin touchstones that are most important in making a decision that is consistently fair and in the public interest. And if the judge makes a mistake — as judges sometimes do — that case will go to court more quickly and at less cost for both the agency and the respondent.

Historically, DMQ nonadopts very few proposed decisions, and rejects very few stipulations. The time DMQ must spend on fact-finding in individual cases leaves less time for other kinds of decisionmaking that is vitally needed and to which the members are better suited. The cost of the current system — including time, money, and lost opportunity costs — seems to outweigh the system's output: the nonadoption of very few proposed decisions and the rejection of very few stipulations.

2. The consistency of DMQ decisionmaking is unclear. DMQ decisionmaking is fragmented. DMQ is split into two panels, neither of which knows of the other's decisionmaking in similar cases. DMQ membership is constantly shifting and changing. There is little or no *stare decisis* — the legal doctrine under which courts adhere to precedent (prior decisionmaking in similar cases) on questions of law in order to ensure certainty, consistency, and stability in the administration of justice — in administrative agency proceedings. Although Government Code section 11425.60 permits DMQ to designate all or any part of a disciplinary decision as a "precedent decision" to promote consistency in decisionmaking, encourage settlements, and avoid costly litigation, DMQ has made no use of its "precedent decision" authority.

3. The procedure utilized at DMQ oral arguments is flawed. When DMQ nonadopts a proposed decision, it is required to afford the parties an opportunity for oral argument before making its final decision. DMQ's oral argument proceedings are most unusual. The usual reason for a nonadoption is that DMQ is considering a harsher penalty than that recommended by the ALJ; thus, the respondent physician is turned into a petitioner. That respondent must be mystified when he arrives at the hearing to find that the Board is represented by its own counsel — HQE. In effect, the "client" hears argument from its own counsel, with which it frequently interacts and upon whom it depends for legal advice on a myriad of matters.

MBC regulations require an ALJ to preside over oral arguments, to ensure that someone legally trained is available to rule on evidentiary objections, require counsel and the respondent to stick to evidence that was admitted at the hearing, and control the proceeding. However, the ALJ presiding over oral argument cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue; so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. The required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ. The respondent must be given an opportunity to address DMQ; however, neither the statute nor the regulations require that the respondent be put under oath when he makes a statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections. This entire process and its attendant costs could be obviated if the original ALJ's decision were designated as the final decision.

4. DMQ's procedures on motions for a stay in order to seek reconsideration appear unfair. Some defense counsel we interviewed complained that their motions for a short stay of the effective date of a disciplinary decision are "always denied," while HQE's motions for a stay are "always granted." In addition, they argued that MBC's Enforcement Chief (and not the DMQ panel) rules on motions for stay — which is why HQE motions for stay are "always granted" and defense motions for stay are "always denied." Although it appears MBC is within the law in permitting its Enforcement Chief to rule on motions for stay, the Monitor agrees with defense counsel that this appears to be a rather one-sided procedure wherein a representative of the prosecutor is able to make decisions affecting the final outcome of a disciplinary matter.

5. DMQ does not notify both parties if it rejects a stipulated settlement. Defense counsel also complained that when DMQ rejects a stipulated settlement, it notifies only the HQE DAG and not the defense attorney. Sometimes it takes a lengthy period of time for the HQE DAG to contact the respondent's counsel to convey the information that a stipulation has been rejected — during which time respondent's counsel has no information on the fate of his client.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #40: DMQ should engage in a public dialogue on the value and costs of DMQ review of proposed decisions and stipulated settlements. The defense bar and the California Medical Association are concerned about the fairness and consistency of both DMQ decisionmaking and the procedures that result in DMQ decisionmaking.

Recommendation #41: MBC should explore its "precedent decision" authority under Government Code section 11425.60 and begin to make use of it. A well-written legal ruling that

represents the will of the Division can guide licensees, HQE, respondent's counsel, and OAH, and will serve to encourage consistency in subsequent decisionmaking, promote settlements in similar cases, and avoid the time and cost of litigation.

Recommendation #42: DMQ should address the procedural issues raised by defense counsel related to motions for a stay of the effective date of a disciplinary decision in order to file a petition for reconsideration. To preserve both the appearance and actuality of fairness to all parties, MBC enforcement staff should not rule on these motions.

Recommendation #43: Government Code section 11371(c) should be repealed. Section 11371(c), which required OAH to publish a compilation of all MQHP ALJ decisions in order to promote consistency in decisionmaking, has been superseded by Government Code section 11425.60.

Recommendation #44: DMQ should notify counsel for both HQE and the respondent when it rejects a stipulated settlement.

Recommendation #45: Business and Professions Code section 2230(b) should be amended to reflect SB 1950's addition of two new members to DMQ.

JUDICIAL REVIEW OF DMQ DECISIONS

A. General Description of Functions

A physician whose license has been disciplined may seek judicial review of MBC's decision by filing a petition for writ of mandate (also called a "writ of administrative mandamus") in superior court under Code of Civil Procedure (CCP) section 1094.5. Under MBC's unique venue statute, a writ challenging DMQ's disciplinary decision may be filed in any city in which the Board has an office.

In conducting its review of the agency's decision, the superior court reviews the record of the administrative hearing (including the transcripts of the testimony that was presented at the hearing and the exhibits that were introduced). Generally, the focus of the court's review is to determine whether the agency's findings are supported by the weight of the evidence introduced during the administrative hearing, whether the decision is supported by the findings, and/or whether the penalty imposed is within the agency's discretion or constitutes an abuse of that discretion. If the court determines that the findings and conclusions are supported by the weight of the evidence and that the Board acted within its discretion, the court will uphold MBC's decision and deny the petition. If not, the court can grant the petition in part (with respect to those findings it does not find

supported) and deny the petition in part (affirming those portions of the decision which it concludes are supported by the weight of the evidence). The court can also grant the petition altogether, explaining how the findings are not supported by the evidence, the conclusions are not supported by the findings, or how — in its opinion — the penalty constitutes an abuse of discretion. Whenever a petition is granted in whole or in part, the matter is remanded to the Board for further proceedings consistent with the court's ruling.

Either side may challenge the superior court's decision (or any part of the decision) by filing a petition for extraordinary writ in a court of appeal. If the appellate concludes the petition lacks merit on its face and does not believe additional briefing would be helpful, it may summarily deny the writ on the merits, thus obviating the need for oral argument and a written opinion. In most instances, however, the court issues an alternative writ. When an alternate writ is issued, the parties engage in full briefing, the court entertains oral argument, and it issues a written decision. The appellate court determines whether the superior court's findings are supported by substantial evidence and are correct on matters of law. The appellate court's decision may be appealed to the California Supreme Court. Such review is entirely discretionary and is rarely attempted or granted.

B. Initial Concerns of the MBC Enforcement Monitor

1. MBC's venue statute is encouraging "forum-shopping" and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money every year. Under Business and Professions Code section 2019 (which is unique to MBC), a respondent unhappy with a DMQ disciplinary decision may file a petition for writ of mandate in San Diego, Los Angeles, Sacramento, or San Francisco — regardless of where the administrative hearing was held and regardless of where the HQE DAG who prosecuted the case works. This has led to apparent "forum-shopping" on the part of defense counsel in search of a sympathetic judge. This practice is resulting in the inefficient use of judicial resources — overburdening one court disproportionately while other courts are relatively unused by MBC petitioners. Additionally, it is costing MBC and HQE thousands of additional dollars to fly HQE DAGs all over the state for writ hearings.

2. MBC is inappropriately subsidizing the cost of the preparation of administrative hearing transcripts for writ proceedings. When a licensee files a CCP section 1094.5 petition for writ of mandate challenging a DMQ disciplinary decision, that petitioner must request the record of the administrative proceeding from the Office of Administrating Hearings. Under section 1094.5, "[e]xcept when otherwise prescribed by statute, the cost of preparing the transcript shall be borne by petitioner." However, due to the interaction of CCP section 1094.5 and Government Code section 69950, the petitioner generally pays only about one-half of the actual cost of the preparation of the transcript, and MBC is billed for the rest. MBC's underwriting or cross-subsidization of the cost of the preparation of the record in writ of mandate proceedings — to the tune of thousands of

dollars per transcript and many more thousands of dollars each year — is unnecessary and particularly inappropriate in light of its current financial plight.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #46: Business and Professions Code section 2019 should be amended to require legal proceedings challenging the Board's decision following an administrative hearing to be instituted in Sacramento, San Francisco, Los Angeles, or San Diego — whichever is closest to where the administrative hearing was held.

Recommendation #47: Government Code section 11523 should be amended to eliminate the reference to Government Code section 69950 and instead require the petitioner to pay the actual cost of the transcript up front.

PUBLIC DISCLOSURE

A. General Description of Functions

In addition to removing incompetent, negligent, dishonest, and impaired physicians from the marketplace through its enforcement program, another way in which MBC implements its "paramount" public protection priority is by disclosing licensee information to the public, to enable consumers to make informed choices when selecting a health care practitioner. The Board's public disclosure policy is an important complement to its enforcement program. This report describes many limitations on the Board's ability to protect the public through its enforcement program — including limitations that are within its control and others that are beyond its control. As a result of these flaws, it is unreasonable to expect that MBC will be able to promptly excise all dangerous physicians from the marketplace. Even assuming these flaws are addressed and resolved, consumers are simply entitled to information about the people to whom they are entrusting the health and lives of themselves and their families. It is thus reasonable to expect MBC, as a complement to its enforcement program, to provide consumers with true, accurate, and complete information about its licensees so they can make informed choices and protect themselves from physicians with whom they would prefer not to deal.

Chapter XIII describes legislation that has expanded MBC's public disclosure policy since 1993, when it disclosed nothing but its own disciplinary decisions against physicians. Today, MBC discloses "public information" on physicians in two ways: (1) Under sections 2027 and 803.1, MBC makes use of the Internet to disclose a variety of information on California physicians, including the status of the license (and whether it is subject to an ISO, TRO, or has been revoked, suspended, put on probation, or restricted by MBC — including limitations that are part of a probationary order or

stipulation); prior disciplinary action taken by other state medical boards; felony convictions reported to MBC after 1991; current accusations filed by HQE; malpractice judgments and arbitration awards reported to MBC after 1993; hospital peer review actions that resulted in termination or revocation of privileges; public letters of reprimand; and infractions, citations and fines. In 2002, SB 1950 authorized MBC to disclose on the Internet some medical malpractice settlements. Most categories of information disclosed on the Internet are disclosed for a ten-year period; a few are disclosed indefinitely. (2) MBC discloses other "public information" that is not subject to Internet disclosure in response to specific request or a formal Public Records Act request. MBC does not disclose other "public information" (including misdemeanor criminal convictions and some civil malpractice settlements) at all; consumers may obtain this "public information" at county courthouses.

B. Initial Concerns of the MBC Enforcement Monitor

1. The fragmented tangle of overlapping statutes frustrates the purpose of MBC's Web site, unnecessarily exposes MBC to litigation, and results in the disclosure of different information depending on the mode of inquiry. One important purpose of MBC's Web site was to provide the public with easy access to all public information about California physicians. However, that intent has been frustrated by the language of the statutes themselves. As a result of the interaction of many statutory provisions, there are essentially four categories of "information" on physicians and three ways to obtain some (but not all) of it — and one receives different information depending on how and who one asks. The statutes appear to contain internal inconsistencies, inadvertent drafting errors, and other problems that are exposing MBC to costly litigation. The better approach may be to draft clean-up amendments that harmonize the various provisions and ensure that all "public information" known to the Medical Board is posted on its Web site.

2. SB 1950's civil settlement disclosure provision has had minimal effect. For the first time, 2002's SB 1950 authorized MBC to disclose some civil malpractice settlements. MBC must classify physician specialties as "high-risk" or "low risk," and may disclose three or more civil settlements against a "low-risk" physician and four or more civil settlements against a "high-risk" physician if the requisite number of settlements is agreed to within a ten-year period. MBC is not permitted to disclose the actual dollar amount of a settlement, but instead must classify it as "above average," "average," or "below average" as compared to other settlements agreed to by physicians in the same specialty during the prior ten years. Additionally, when it discloses civil settlements, the Board is required to attach a lengthy disclaimer mandated in section 803.1(c). In almost two years since SB 1950 became effective, the Medical Board has disclosed civil malpractice settlements on a grand total of seven physicians — all of whom have agreed to four or more settlements since January 1, 2003.

It is unclear why consumers are deprived of information on civil settlements, which are increasingly public information since the Judicial Council adopted rules prohibiting the sealing of court records in 2001. Civil malpractice settlements are reached in the context of a public judicial proceeding financed with taxpayer money in which the physician has every opportunity to be represented by counsel and to reject the settlement — and the proceeding pertains to the physician's professional performance (and not to his personal life). Most importantly, insurers, hospitals and HMOs, and the Board itself demand, obtain, and rely upon a physician's complete malpractice history before determining whether to ensure, grant privileges to, or license that physician. Only consumers are left in the dark.

3. MBC is not authorized to disclose misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. Since 1993, MBC has disclosed felony criminal convictions against physicians. However, it has never disclosed misdemeanor criminal convictions — including those convictions which were originally charged as felonies and/or "wobblers" but were pled down to misdemeanors. Conviction of a misdemeanor that is substantially related to the qualifications, functions, and duties of a physician is grounds for disciplinary action. A misdemeanor criminal conviction is either an admission or a finding by a jury or court — beyond a reasonable doubt — of the commission of an act which has been categorized as a crime by the Legislature. Further, a misdemeanor criminal conviction is public information.

4. MBC is not disclosing all significant terms and conditions of probation on its Web site. Although state law requires MBC to post information about "probations" and "limitations" on its Web site, the Board does not consistently do so — due in part to limitations imposed by its CAS computer system. MBC is working to resolve this issue by revamping its Web site to afford online access to public documents — including all terms and conditions of probation.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #48: Sections 2027 and 803.1 should be consolidated and harmonized to implement the purposes behind AB 103 (Figueroa)'s creation of MBC's Web site: "allowing the public easy access to important information about physicians, particularly in the area of medical negligence . . . ." The fine-tuning of these two sections would also eliminate drafting errors and inconsistencies between the two statutes that have caused confusion and expensive litigation; save MBC time and money by ensuring that most public information is posted on the Board's Web site; and ensure that information disclosed to consumers by MBC is consistent and accurate regardless of the way in which the consumer asks for it.

Recommendation #49: All medical malpractice settlements exceeding $30,000 should be disclosed on MBC's Web site with the disclaimer currently required in section 803.1(c).

Subsequent experience has now shown that the compromised reached in 2002 — which has resulted in the disclosure of the settlements of only seven physicians — is not a "publicly credible program of public disclosure" as demanded by the Board and the JLSRC in 2002. Especially in light of the fact that all other stakeholders demand and rely on a physician's complete malpractice history, MBC's disclosure of medical malpractice settlements should be expanded.

Recommendation #50: All misdemeanor criminal convictions substantially related to the qualifications, functions, and duties of a physician should be disclosed on MBC's Web site. As recommended by the Federation of State Medical Boards, these "substantially related" criminal convictions should include "misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, and violations of public health and safety codes."

Recommendation #51: MBC should disclose all significant terms and conditions of public probation orders on its Web site. MBC should continue in its efforts to revise its Web site so that consumers can access public documents — including complete Board disciplinary decisions and stipulations that set forth all significant terms and conditions of probations.

Recommendation #52: Section 2027 should be amended to permit MBC to disclose the resignation or surrender of hospital privileges after the hospital has notified the physician of an impending investigation under section 805(c). The number of disclosable section 805 reports has dwindled significantly to six in 2003–04, such that the intent behind section 2027(a)(6) — public disclosure of serious peer review actions — is being defeated.

PUBLIC EDUCATION AND OUTREACH

A. General Description of Functions

In 2002, MBC created a Public Education Committee (PEC), whose goals are to (1) increase the number of Californians who know of the existence of the Board and its enforcement program by bringing together representatives of organizations to develop better ways of communication, and (2) encourage officials and entities that are required to report certain information to the Board to do so. Under PEC's guidance, MBC uses a number of methods — including its Web site, its *Action Report* licensee newsletter, speeches and presentations, brochures and fact sheets, and the media — to educate and communicate with consumers, licensees, mandated reporters, prospective expert reviewers, and other stakeholders regarding the Board's enforcement program. Additionally, the enforcement program is responsible for communicating with complainants and complained-of physicians during complaint processing and investigations.

B. Initial Concerns of the MBC Enforcement Monitor

1. Physicians are not required to provide patients with information about the existence of the Board and its disciplinary jurisdiction. Other California regulatory agencies — including healthcare-related agencies — require their licensees to provide some form of notice to clients, patients, and customers about the existence and jurisdiction of the regulatory agency. The Medical Board has not implemented such a requirement. Data collected for this report reveal that many patients who are injured by physicians do not file a complaint with the Medical Board, thus thwarting the Board's ability to protect future patients. The Monitor believes that, as a matter of sound public policy, the Medical Board should make better efforts to meet its obligation to assist victims of medical wrongdoing in understanding how to be involved with its enforcement program.

2. The Board does not communicate consistently with physicians during the complaint review and investigative process. MBC has made a concerted and apparently successful effort to improve its communications with complainants throughout the complaint handling process. Its communications with subject physicians seem less consistent.

3. MBC should communicate with local county medical societies about their obligations under Civil Code section 43.96. This provision requires medical societies, hospitals, and local government agencies that receive a written complaint against a physician to affirmatively notify the complainant that they have no jurisdiction over the physician's license and that only MBC may discipline a physician's license. MBC should ensure that these entities — which consumers often confuse with the Medical Board — are not filtering meritorious complaints away from MBC's enforcement program.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #53: Physicians should be required to inform patients about the Medical Board's existence, disciplinary jurisdiction, address, and toll-free complaint number. MBC should implement a system to ensure that its licensees inform the patient public about its existence and enforcement role. Physicians could be given a variety of options to accomplish this consumer education — for example, a fact sheet, a posted waiting room notice, or a disclosure on a discharge summary, invoice, or other document routinely given to patients.

Recommendation #54: As suggested in related Recommendation #20, MBC's enforcement program should ensure that complained-of physicians are appropriately notified of complaint dispositions.

Recommendation #55: MBC should periodically communicate with local county medical societies and remind them of their obligations under Civil Code section 43.96, to ensure that those private organizations are properly referring complainants to the Medical Board.

MBC'S DIVERSION PROGRAM

A. General Description of Functions

Created in 1980, the Medical Board's Diversion Program "diverts" substance-abusing physicians out of the enforcement program described above and into a program that is intended to monitor them while they attempt to recover from the disease of addiction. The Diversion Program designs a contract that includes terms and conditions of participation for a five-year monitoring period, including random bodily fluids testing, required group meeting attendance, required worksite monitoring, and often substance abuse treatment and/or psychotherapy. Those who comply with the terms and conditions of their Diversion Program contract may be "successfully terminated" from the Program after three years of continuous sobriety. Those who violate the terms and conditions of their Diversion Program contract may be "unsuccessfully terminated" from the Program and referred to the enforcement program for disciplinary action. During their participation in the Program, these physicians generally retain their full and unrestricted license to practice medicine, and many of them are in fact permitted to practice medicine subject to the terms and conditions of their contracts. Many of them participate in absolute confidentiality — their participation in the Diversion Program is secreted from the Board's enforcement program, their patients, and the public.

The Diversion Program is a *monitoring* program, not a treatment program. It does not provide substance abuse treatment; its staff are not authorized or trained to do so. Instead, it evaluates the needs of its participants; provides a rehabilitative plan that directs them to treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy, as appropriate; monitors their compliance with the terms and conditions of their contract with the Program; and is authorized to terminate them from the Program (and refer them to the enforcement program) if they do not comply.

DMQ is responsible for administering the Diversion Program. In 2000, MBC created a standing Committee on the Diversion Program to oversee the Program; the Committee meets quarterly and makes recommendations to DMQ.

The Diversion Program is staffed by ten employees, including a Program Administrator, five regional case managers (CMs) responsible for ensuring that participants in their geographic area comply with the terms and conditions of their Diversion Agreement, and four support staff in Sacramento (including a "Collection System Manager" (CSM) who is responsible for overseeing the

Program's urine testing system). These employed staff are assisted by 13 "group facilitators" (GFs) based throughout the state; GFs facilitate biweekly group meetings of Diversion Program participants in their community. Additionally, approximately 30 local businesses across the state serve as urine specimen collectors for the Diversion Program. Pursuant to a random schedule generated by the CSM, these collectors are expected to conduct observed urine collections on the dates specified and to immediately transmit the specimens to a Program-approved laboratory for testing. Lab test results are emailed to the CSM and downloaded to each participant's file in the Program's computerized Diversion Tracking System (DTS).

Other external guidance is provided to the Diversion Program in the form of Diversion Evaluation Committees (DECs), regional five-member panels that meet with applicants to the Diversion Program and advise the Program Administrator whether the applicant should be accepted and on appropriate terms and conditions of the Diversion Agreement (including practice restrictions). The DECs act in an advisory capacity to the Program Administrator. Finally, an external "Liaison Committee to the Diversion Program" (LCD) created by DMQ and CMA in 1982 consists of physicians and other licensed professionals whose careers are dedicated to substance abuse detection, treatment, and rehabilitation; the LCD is intended to bring clinical expertise and external information to DMQ and the Medical Board staff who administer the Diversion Program.

As the Diversion Program has not been externally audited in 18 years, SB 1950 (Figueroa) directed the Enforcement Monitor to examine the Program. As such, Chapter XV provides detailed information on the methodology used by the Monitor in determining whether the Program is functioning consistent with its statutes, regulations, and procedure manuals. Chapter XV also describes the statutory purpose of the Program; its structure, staffing, and funding; and the functioning of the Program and its various monitoring mechanisms intended to detect relapse or pre-relapse behavior. Chapter XV also describes prior audits and studies of the Diversion Program, including a series of three audits by the Auditor General in the 1980s which found significant deficiencies with the Program's monitoring of substance-abusing physicians and with the Medical Board's failure to properly oversee and administer the Program.

B. Initial Concerns of the MBC Enforcement Monitor

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary

purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are random urine screening requirements, case manager attendance at required group meetings, required worksite monitoring, and regular reporting by treating psychotherapists. All of these monitoring mechanisms are failing the Program and the public, and the Program lacks internal quality controls that would otherwise enable staff to detect these failures. As a result, Program staff and oversight authorities are unaware of the deficiencies that exist in the Program and falsely assume that the Program is effectively monitoring participants when it is not.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means for monitoring participants' sobriety and detecting relapses. Available data suggest that more than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major objective measure of participant compliance with the terms of the contract and with the Program's requirements. However, the results of our review suggest that the confluence of various deficiencies in the current system delays the Program's detection of participant relapses (in some cases for an extended period of time) or prevents that detection entirely. In our view, these deficiencies seriously undermine the integrity of the major objective measurement of participant compliance, and may expose the public to unacceptable risk.

Specifically, there are not sufficient positive controls on the current collection system to provide assurance of six major components: (1) all active participants are included in the master collection schedule generated by the CSM; (2) the participant is scheduled for the correct number of tests per month pursuant to the Diversion Program's "frequency of testing" policy; (3) collections are actually completed on the random date assigned by the CSM; (4) the same number of collections is completed as is scheduled for each participant; (5) collected specimens are received at and processed by the laboratory; and (6) test results are correctly downloaded and appended to each participant's record in the DTS. Due to the absence of sufficient positive controls over the scheduling and collection process, participants can be tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there is a problem. Also, test results may be inadvertently appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there is a problem. All of these events have occurred. Specifically, we found significant defects in four areas of the Diversion Program's urine collection system:

(A) Collection scheduling process deficiencies. In this area, we found that new participants are not always promptly scheduled for urine collections. Although the Program assures the public of "immediate drug testing," our review of 20 recently completed intakes suggests that about 25%

of new participants are not promptly scheduled for any collections (or tested) for a period of at least a month following completion of their intake interview — and most of these participants are permitted to practice medicine. Further, urine collections are not always promptly restarted when a participant completes treatment following a relapse; our review of 20 recent relapse cases identified four cases where urine collections were not promptly restarted following completion of treatment. Finally, the CMs and local urine collectors are undermining the integrity of the Program's random urine testing schedule by failing to ensure that the CSM is notified of the need to add new participants to the random urine collection scheduling system. Our review of 20 recently completed intake cases identified nine cases — almost 50% of the cases we reviewed — where the participants were not randomly scheduled for collections through the CSM for periods ranging from one month to as many as four months following completion of their intake interview or, if applicable, release from treatment. When a participant is not scheduled for testing through the CSM, the case manager and/or collector unilaterally determine when to test the participant. The practice of ignoring or repeatedly overriding the random collection schedule generated by the CSM undermines the integrity of the random collection scheduling system.

(B) Specimen collection process deficiencies. Here, we found that collectors do not usually obtain urine specimens on the dates specified in the CSM's master collection schedule. We compared scheduled collections with actual collections for periods ranging from four to eleven months for each of 20 recently completed intake cases, and found that collections were actually completed on the date that had been scheduled only 40% of the time. There are no controls over many of the changes to the random collection schedule that are made and, in most cases, the reasons for the changes are not documented. Also, collectors disproportionately shift collections from weekend days (Friday, Saturday, and Sunday) to weekdays, particularly Tuesday and Thursday. Among the 20 recently completed intake cases that we reviewed, 22% fewer collections were completed on weekends compared to the number that were scheduled for those days. Significantly more collections were completed on both Tuesdays and Thursdays than were scheduled. The reduced frequency of testing on weekends and increased frequency of testing on Tuesdays and Thursdays potentially enables participants to "game" the system by anticipating when they are least likely to be tested. Finally, we found that collectors do not always make up for collections that are skipped for the convenience of the collector or the participant; as a result, many participants complete fewer collections than are scheduled and required. The systemic rescheduling of collections by case managers and/or collectors raises serious questions about the integrity of the Diversion Program's random collection scheduling system.

(C) Reporting and recordkeeping deficiencies. The Diversion Program's arrangement with the lab calls for positive results to be reported to the Program within 72 hours. However, our review of 20 recent relapse cases identified four cases where positive test results were not reported for timeframes ranging 10 to 14 days after the sample was obtained. In another case, test results were

not reported for as long as 3 to 4 weeks after the sample was obtained. In most cases, reporting delays are attributable to failure by the collector to submit the specimen to the laboratory on a timely basis. Further, there are gaps in the collection records maintained in the DTS. Although DTS is supposed to contain a record of urine test results for all participants from late 2001 to the present, the Diversion Program does not have positive controls to assure that test results are actually received from the laboratory and downloaded to the DTS, test results are appended to the correct participant's DTS file, and the information transmitted from the lab is correct. Finally, the Program requires local urine collectors to file a monthly report detailing the dates of all urine collections on all participants, including the specimen chain of custody number; this monthly report could help Program staff in detecting errors. The Manual also requires local collectors to "cite reasons for adjusting a collection date." However, the vast majority of collectors fail to file monthly reports, and Program staff do not insist on compliance with this requirement.

(D) Urine collection system oversight deficiencies. Program staff do not adequately monitor the collectors. As noted above, collectors appear to have broad discretion to unilaterally modify the collection schedules prepared by the CSM or, in some cases, skip collections altogether. As a result, many participants are not tested on the dates scheduled or are not tested as frequently as required. It is unclear whether Program staff even know these events are occurring. Additionally, Diversion Program staff do not routinely, or even periodically, review individual participant urine collection records. If a positive test is reported for a participant, the case manager initiates consultations with all concerned parties in response to that specific report. However, if no positive test results are reported, Diversion Program staff assume that all required collections have been completed as scheduled, submitted to the laboratory for testing, and reported as negative results. These assumptions are sometimes false. In most cases, specimens are not collected on the dates scheduled and, in many cases, specimens are not collected as frequently as required. In some cases, specimens are not collected at all for extended periods of time and nobody, other than the participant, is aware that this is occurring. Finally, prior to April 2004, the Program had no policy for response to so-called "negative-dilute" test results. Sometimes, participants who have resumed use of drugs or alcohol attempt to "dilute" their urine by ingesting large quantities of liquid. In many cases, negative-dilute test results clearly reflect a participant's efforts to disguise his relapse. Therefore, negative-dilutes should be recognized and addressed immediately. After the Monitor pointed out several instances where a pattern of negative-dilute specimens was followed by a relapse, the Program implemented a new policy to handle negative-dilute test results.

The results of our review suggest that at least several dozen of the Diversion Program's current participants have, at some point, not been tested for an extended period of time when they should have been. The results of our review also suggest that many more participants are not being consistently tested as often as they should be. Nobody currently makes any effort to track or monitor actual collections on a proactive basis for purposes of (1) controlling unapproved changes to the

collection schedule that otherwise might be made for the convenience of the collectors or participants, (2) assuring that the required number of tests is actually completed for each participant, and (3) detecting relapse behaviors in advance or in lieu of actually receiving a positive test result.

To summarize, the Diversion Program today in 2004 is plagued by the same problem found by the Auditor General in 1985 and again in 1986: The Diversion Program cannot guarantee the public that its participants are being tested as frequently as it requires. Focusing specifically on Diversion Program participants who are permitted to practice medicine, about one-half of recent intakes were not tested as often as required during the first one to four months of participation. About 25% of new participants were not tested at all for at least one month following completion of the intake interview. The relapse cases we reviewed indicated that five of the 20 participants who relapsed — all of whom were practicing medicine — were not tested as often as required. The public is exposed to unnecessary risk.

The Monitor alerted Diversion Program and MBC management to the confluence of these problems within the Program's urine collection system in June 2004, and management immediately convened a small working group consisting of two Board members, MBC and Diversion staff, and representatives of the Monitor team. The working group has met three times and is working toward resolution of these problems.

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The Program's case managers represent another "monitoring" mechanism of the Diversion Program. The *Diversion Program Manual* requires case managers to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants. Case managers are required to report their group meeting attendance in monthly reports to the Program Administrator. However, few case managers file monthly reports as required. In August 2004, we looked at the Program Administrator's binders of CM monthly reports for 2003 and 2004. One case manager submitted one monthly report in 2003 and none in 2004, and another submitted no monthly reports in 2003 and two in 2004 — so there is no documentation as to whether they have attended group meetings as required by Program policy. Three other case managers submitted monthly reports fairly regularly during both years; two of those CMs reported attending the meetings of only one or two groups in their locale per month, while the other attended the meetings of five to seven groups per month. The problem of inconsistent or inadequate contact by case managers with participants was identified by the Auditor General in 1982, 1985, and 1986. The problem of inadequate reporting by case managers and inadequate supervision of the case managers by the Program Administrator was identified by the Auditor General in 1985 and 1986. Little has changed.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are "monitored" by non-impaired

physicians. However, the Program has set forth no workable definition of the duties, qualifications, or expectations of a "worksite monitor." Although some Diversion Program materials convey the idea that participants are "supervised" while practicing medicine, that is not the case. There are no requirements that the worksite monitor actually be onsite at the same time as the participant, supervise the participant in any way, or even meet with or talk to the participant. There are no qualifications or criteria for someone functioning as a "worksite monitor"; the monitor is not even required to be a physician. In fact, the Program Administrator stated that, on occasion, the Program is required to approve a physician's office manager — someone who is hired and fired by the participant — as the worksite monitor. Additionally, people functioning as worksite monitors are not consistently filing quarterly reports as required by the Program. The quarterly worksite monitoring reports constitute a promise made by the Diversion Program to the public, and are a key mechanism for communication between the worksite monitors and the case managers. The Program's failure to adequately define the duties, qualifications, and functions of "worksite monitors" and the failure of worksite monitors to submit quarterly reports were identified by the Auditor General in 1982, 1985, and 1986. Little has changed.

(4) Treating psychotherapist reporting is deficient. The Diversion Program assures the public that impaired physicians are also monitored by treating psychotherapists who are required to file quarterly written reports with the Program. However, this monitoring requirement is not being satisfied. Neither the case managers, the Program Administrator, nor the DECs (which annually review all Program participants) are ensuring that quarterly treating psychotherapist reports are filed.

b. The Program is so understaffed that staff could not correct these failures in its monitoring mechanisms even if they knew about them.

There is significant understaffing at all levels of the Diversion Program. During the past ten years, the Program has suffered a 22% increase in participation with no increase in staffing. The Program Administrator is expected to handle functional supervision, program oversight, and program development — a burdensome combination of duties which one person cannot competently handle alone. Beginning in March 2002, the caseloads of some Program case managers were deemed so excessive that Program management curtailed entry into the Program by participants who would be served by those case managers and simultaneously lessened the participant monitoring expected of those case managers. Of particular importance, the Collection System Manager position is significantly understaffed. Although the *Diversion Program Manual* promises a dedicated CSM position responsible for the overall oversight and coordination of the collection system process, the individual currently serving as the CSM is able to spend only about two hours per month on CSM duties.

In our observation and based on our reviews of Diversion Program files, the case managers and the Program Administrator are so overloaded that all they are able to do is react to relapses. The

case managers do not adequately monitor their caseloads, enter all required data in the DTS, or forward all required materials to Sacramento. Neither the case managers nor the Program Administrator were aware of any of the problems we found with the urine collection system described above. The four Sacramento-based support staff cannot possibly keep up with their Program-related work responsibilities (including the calendaring and staffing of all DEC meetings all over the state) plus the work necessary to accommodate the needs of the Diversion Committee, the Liaison Committee, and the Division of Medical Quality. Many issues referred by the Diversion Committee to staff for study — or to the Liaison Committee to be assisted by staff — simply fall through the cracks and are never resolved because of the paucity of analytical staff.

The Program's staff must be significantly augmented. Having said that, the Monitor must emphasize that the mere addition of staff alone will not solve the Diversion Program's problems. As described above, the Program lacks significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. If those monitoring mechanisms fail (as they have), and if there are inadequate internal quality controls to detect that failure (as there are), both the physicians in the Diversion Program and the public whose safety is the "paramount" priority of the Medical Board are exposed to serious risk. It is abundantly clear that the Program has functioned without adequate internal controls for 24 years. These controls must be designed, installed, and adequately staffed.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held. Compounding the failure of its monitoring mechanisms and understaffing problems described above, the Diversion Program is plagued by an almost complete lack of clear and enforceable rules, standards, or expectations to which participants are held. The Diversion Program's decisionmaking is characterized by an unacceptable "case-by-case basis" mentality which promotes inconsistent decisionmaking and serves the interests of neither the participants nor the public.

The Diversion Program's statutes and regulations are skeletal at best, and set forth few enforceable rules, standards, or expectations for either the Program or its participants. None of the monitoring mechanisms described above are mentioned in, much less governed by, statute or regulation. All of these monitoring mechanisms are contained in an unenforceable "procedure manual" that has rarely if ever been scrutinized by DMQ — which is statutorily responsible for administration of the Program — or even the Diversion Committee.

The *Diversion Program Manual* similarly sets forth no clear rules and no mechanisms to ensure standardized and consistent decisionmaking about potentially dangerous physicians. Diversion Program decisionmaking is excessively fragmented. When a relapse occurs, that event (which is detected by the Program days or even weeks after the test) sets in motion a complex and

time-consuming chain of communications between various Program personnel (the CM, GF, the DEC consultant assigned to the participant, and perhaps the entire DEC which may be polled by telephone) and the participant, the lab, the participant's worksite monitor and/or hospital monitor, and the hospital well-being committee. These contributors to the ultimate Program decision, who are already hampered by inadequate recordkeeping, have no clear standards to guide their decisionmaking — a dynamic which can lead to inconsistent decisionmaking. The Program is further hampered by the absence of consistently applied and enforceable rules regarding consequences for relapse, and criteria justifying termination from the Program. Lacking any clear statutory or regulatory guidance, the *Manual* contains one policy regarding relapse, which states that "a participant will be considered for termination when the participant has more than three relapses while in the Program." This "three-strikes-and-you-may-be-out" policy is arguably underground rulemaking and, in any event, is inconsistently applied.

In 1982, the Auditor General detailed six cases in which participants egregiously violated the terms of their Diversion contracts but were not terminated from the Program; according to the Auditor General, "[t]hese deficiencies result from a lack of established standards and guidelines for terminating participants." In 1985, the Auditor General detailed three matters where the participant repeatedly violated significant terms and conditions of the contract and should have been suspended from the practice of medicine and/or terminated from the Program but was not; the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly." Twenty years later, DMQ has still failed to establish meaningful and enforceable standards for the handling of relapse by Diversion Program participants and for termination from the Program. Nor has it addressed the loopholes in the law that permit "chronic relapsers" to repeatedly enter, withdraw from, and reenter the Program. In light of the Program's budget constraints, understaffing, and significant absence of internal controls, it is unfair to subject the public to a repeat offender who is able to manipulate the system and remain licensed.

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program. State law requires DMQ to administer the Diversion Program and oversee its functioning. MBC's Diversion Program is one of only four in the nation to be housed directly within a state medical board — subject to its direct supervision and oversight. One must assume that the purpose of this in-house structure is to enable members of the Medical Board to affirmatively oversee the Diversion Program to ensure that the public is protected from impaired physicians. However, this has not happened. Instead, in 1982, the Division of Medical Quality effectively delegated its authority over the Diversion Program to the Liaison Committee — which has no statutory existence or authority — and to the staff of the Diversion Program, which in the past has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.

The Auditor General reports of the 1980s universally found that the Division has failed to adequately supervise and oversee the Diversion Program. The 1985 report could not be more clear: "The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. . . . The medical board has allowed these problems to develop because it has not adequately supervised the diversion program."

In 1998, DMQ made an effort to reclaim its jurisdiction over the Diversion Program, and in 2000 established a standing Committee on the Diversion Program to meet quarterly to discuss Diversion-related issues. The Committee has done its best to fashion procedures to enable it to oversee the Program, including its review of "Quarterly Quality Review" reports on the Program's responses to intakes, relapses, and releases. However, the Committee remains at the mercy of staff in terms of the information that it receives — and at no time has staff apprized the Committee of any of the serious issues described above by the Monitor. The Committee has attempted to address a number of major issues which have been repeatedly raised; they are referred either to staff or to the Liaison Committee and remain unresolved due to the volunteer nature of LCD, its infrequent meeting schedule and unclear agenda, and the Diversion Program's lack of staff.

The governance of the Diversion Program must be transformed into an accountable structure with a sufficient number of staff who are able and willing to implement DMQ's instructions, with monitoring mechanisms that provide DMQ with an ability to meaningfully oversee both staff and participant compliance with policies and procedures (preferably statutes and regulations) that it has approved and the Program's response to specific cases. If this structure is not possible, or if DMQ is unwilling to fully design and participate in it, then the Diversion Program should be abolished and the licenses of impaired physicians should be suspended until they prove that they are capable of safe medical practice.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC management. For many years, the Medical Board — both the Board and its staff — has permitted Diversion to effectively function in a vacuum. Considering the current confidentiality under which the Diversion Program operates, it is not unreasonable that the identities of self-referred Diversion Program participants be concealed from the enforcement program and from MBC management. However, the entire operation of the Diversion Program has been walled off from the rest of MBC management. This separation has resulted in breakdowns in key Diversion Program monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which have not been communicated to MBC management so that management might address it. In Chapter XV, the Monitor describes several examples of this management failure, including the fact that the Diversion Program has allowed its *Diversion Program Manual* to become almost completely obsolete.

5. The Program's claim of a "74% success rate" is misleading. In its March 2000 brochure, the Program announced that "[f]rom the inception of the Diversion Program in 1980 to March 1, 2000, there have been 981 participants. Six hundred sixty-three (663) of these have completed the program successfully. After factoring out physicians who did not complete for reasons unrelated to their disorders, this results in a 74 percent success rate." This is misleading. While it appears to convey effectiveness in assisting participants to recover from substance abuse, it means only that 663 physicians completed the program and were "successfully terminated." The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Monitor has also heard Program staff and supporters make statements to the effect that "no patient has ever been injured by a physician in the Diversion Program." This is similarly misleading. Injury to patients is not a type of information that the Program captures or publicizes. As demonstrated above, the Program does not even know whether its participants are being drug-tested as frequently as its own policies require, or whether they have adequate worksite supervision, or whether their treating psychotherapists are properly reporting on their patients' progress. The Program should be less concerned with "spin" about its effectiveness and more concerned about real-time monitoring of impaired physicians to protect the public.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #56: Based on the information contained in this and prior reports on the Diversion Program, the Medical Board must reevaluate whether the "diversion" concept is feasible, possible, and protective of the public interest. The Medical Board's paramount priority is public protection. It is unclear why a board charged with public protection as its paramount priority would permit physicians who are addicted to drugs or alcohol to practice medicine before they have recovered from that addiction. If such a board believes that impaired but recovering physicians should be permitted to practice medicine while they are in recovery and susceptible to relapse, that board must insist on comprehensive monitoring mechanisms which are demonstrably effective in detecting both relapse and pre-relapse behaviors, to protect both the participant and the public at large. According to the clear findings in three Auditor General reports and this report, this Board's Diversion Program has never consistently — if ever — had those monitoring mechanisms in place in all cases and at all times, thus exposing the public to unacceptable risk in violation of Business and Professions Code sections 2001.1, 2229, and 2340. The Medical Board must determine whether it is possible to develop, resource, and ensure the effective monitoring mechanisms demanded by state law, or whether the public interest demands that the licenses of impaired physicians be suspended during periods of impairment.

Recommendation #57: If the Board determines that it is possible to implement the "diversion" concept consistent with the public interest, the Board must then determine

whether to house that diversion program within the Medical Board or contract it out to a private entity. This Board has evaluated that question on several occasions (most recently during its 2002 strategic planning session), and has determined to preserve the Program within the Medical Board. However, the Board did not have access to the findings in this report at that time. Nor did it have full and objective information on the alternative structures currently used by other state medical boards or California agencies. The Board must undertake an informed and objective study of all other models used by other state agencies with diversion programs.

Recommendation #58: If the Medical Board decides that "diversion" is feasible and that administration of the Diversion Program should remain within the Medical Board, the Division of Medical Quality must spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that limit the Program's effectiveness both in terms of assisting participant recovery and in terms of protecting the public. This overhaul must include an influx of staff resources (including — at the very least — the addition of a manager to supervise the case managers, a sufficient number of case managers so their caseloads never exceed 50 cases, and a full-time Collection System Manager whose entire job is devoted to ensuring the integrity of the Program's urine collection system) and the installation and staffing of internal quality controls to assure the Division, Program participants, and the public that the Program's monitoring mechanisms are effective in detecting relapse into drug/alcohol use. The restructuring must also include the long-overdue adoption by DMQ of meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse (see Recommendation #62 below). If the Division adopts clear standards applicable to relapse and termination from the Program, it may be that significant staffing additions are unnecessary because noncompliant participants will be terminated from the Program more quickly.

Recommendation #59: The Division of Medical Quality must reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it is currently structured. Consistent with its comprehensive restructuring of the Diversion Program in Recommendation #58 above, the Division must determine whether there is a need for external clinical expertise and — if so — convert the Liaison Committee into a workable advisory panel that serves the needs of DMQ as determined by DMQ.

Recommendation #60: The Division of Medical Quality must determine whether Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Diversion Program. Significant staffing constraints plague the Diversion Program, and those staffing constraints negatively impact its ability to monitor participants and protect the public. Even the Program has recognized that it cannot simply keep accepting more participants. DMQ must decide how the Program is to be structured and funded.

If Program participation must be capped, the Division must further consider who should have priority — Board-ordered participants, Board-referred participants who enter under a statement of understanding with the enforcement program, or self-referred physicians.

Recommendation #61: Regardless of whether Diversion Program participation is deemed an entitlement or is capped to accommodate staffing and protect the public, the Diversion Program's budget should be earmarked and separated from other MBC program budgets. The Diversion Program should be funded by a specified and identifiable portion of MBC license fees paid by all California physicians, and by participation fees paid by participants (who currently pay nothing toward the overhead of the Program). In particular, the Monitor agrees with the Auditor General's 1995 recommendation that physicians who are ordered to participate in the Diversion Program as a term of probation should pay their proportionate share of the overhead costs of the Program. Indigent physicians who are so impaired that they are unable to work should not have to pay participation fees. DMQ should research and evaluate other sources of revenue to fund its Diversion Program, including contributions from state medical societies, malpractice carriers, and hospitals.

Recommendation #62: DMQ must establish enforceable standards and consistent expectations of participants and Diversion Program staff through legislation or the rulemaking process, oversee a comprehensive revision of the Diversion Program's policy manual, and ensure that Diversion Program management is integrated into overall MBC management. The Monitor recommends that DMQ consider enforceable standards in a number of areas: (1) to prevent chronic relapsers from consuming scarce Program resources, DMQ should consider adopting a "deferred entry of judgment" mechanism similar to that in Penal Code 1000; (2) alternatively, the Division should consider banning Diversion Program participation to anyone who was previously a participant in the Program pursuant to an SOU, a stipulation, or Board-ordered probation within a specified number of years and who failed to successfully complete the Program; (3) in adopting criteria for termination from the Program, the Division should consider adopting in regulation the Program's current "three-strikes-and-you-may-be-out" policy (which is arguably underground rulemaking); and (4) the Monitor also recommends that the Division consider a required (or at least presumed) "cease practice" period at the commencement of Program participation to enable a full-scale interdisciplinary evaluation of the extent of the physician's addiction, afford time for necessary treatment, and encourage the physician to focus on recovery.

Additionally, DMQ must ensure that the *Diversion Program Manual* is completely rewritten to incorporate the impact of all relevant statutory and regulatory changes. And MBC management must effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management, to ensure that Diversion staff are knowledgeable of enforcement procedures which impact its Board-ordered participants.

Recommendation #63: DMQ should explore various methods of assessing the long-term effectiveness of the Diversion Program in assisting physicians in recovering from substance abuse.

Recommendation #64: The Medical Board should continue its efforts to replace and upgrade the Diversion Tracking System.

Recommendation #65: The Medical Board's Diversion Program should undergo a full performance audit by the Bureau of State Audits every five years. Under no circumstances should 18 years pass between external performance audits of this critically important program which is permitted to operate in secrecy.

CONCLUSION

To be effective, a report such as this must focus for the most part on the shortcomings in the system under scrutiny. However, the Monitor also notes that there is much that is good at the Medical Board of California and the Health Quality Enforcement Section of the Attorney General's Office, and that the Monitor has consistently encountered a spirit of cooperation and a commitment to progress among the public servants who undertake this important duty. In particular, the Monitor has found a dedicated and hardworking MBC staff who have diligently maintained their mission in the face of substantial resource reductions, and an equally dedicated and skilled staff of attorneys in HQE, who have also labored to do more with less. MBC's new Executive Director David Thornton brings in-depth knowledge of enforcement processes and impressive experience and management skill to this post, and he is rapidly responding to the organizational problems facing MBC, including many of those described in this Initial Report. Both the Board and HQE are blessed with experienced senior managers with extensive system knowledge and a highly constructive attitude toward institutional change and improvement. The Board itself is conscientious and public-spirited, with outstanding professional credentials and demonstrated commitment to public protection.

MBC, HQE, and associated organizations must continue to address substantial concerns to better meet their statutory obligation to protect the California public. If given adequate resources and an improved structure and process, MBC and HQE should be expected and required to achieve significant improvements in prompt and efficient handling of consumer complaints by a well-trained staff utilizing consistent criteria and procedures; timely and effective enforcement action, facilitated by close coordination and teamwork, and appropriately tailored to the circumstances of each case; educating and communicating with the medical community and the public these agencies serve; and an effective Diversion Program that demonstrably protects the public while monitoring and assisting troubled physicians.

To help promote and document such improvements, the MBC Enforcement Monitor will continue to work closely for the statutory term with the Legislature, the Department of Consumer Affairs, MBC, and HQE and their respective managements and staffs, the medical community, and the public whose protection is the agency's central mandate.